Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 11, 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 31, Aug 1, 2, 3, 7, 8, 9, 10, 13, 2012	2012_039126_0001	Resident Quality Inspection

Licensee/Titulaire de permis

HILLTOP MANOR NURSING HOME LIMITED
82 Colonel By Crescent, Smiths Falls, ON, K7A-5B6

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

HILLTOP MANOR NURSING HOME LIMITED
1005 ST LAWRENCE STREET, P.O. BOX 430, MERRICKVILLE, ON, K0G-1N0

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

LINDA HARKINS (126), KATHLEEN SMID (161), LYNDA HAMILTON (124)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care(DOC), several Registered Nurses(RN), several Registered Practical Nurses(RPN), several Personal Support Workers (PSW), Dietary staff members, Activity staff members, Physiotherapy/Restorative staff members, Maintenance/Housekeeping/Laundry staff member, residents, family members and the President of the Resident Council.

During the course of the inspection, the inspector(s) reviewed several resident's health care records, reviewed policy and procedure manuals, reviewed staff schedules, observed several meal services, examined several resident rooms and common areas, and observed care and services given to residents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Amendment: September 20, 2012
It is noted that during this inspection, an immediate Order CO # 901, was issued on July 11, 2012, related to O.Reg 79/10 s. 130 (Security of Drug Supply).
This Order was back in compliance as of July 13, 2012

L Duchesne. 20 Sept 12.

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Training and Orientation

Trust Accounts

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

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:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
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.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
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:
1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 r.110 (7) 1 in that the documentation does not include the circumstances precipitating the application of the physical device.

In July 2012, resident # 16 was noted to have a restraint that he/she could not undo. Staff members # 104 and # S105 reported to Inspector #126 that they did not know why the resident had a restraint.Resident # 16's health care record was reviewed by Inspector #126 and there was no documentation of any assessment completed for the application of the restraint.

The licensee has failed to comply with O.Regs 79/10 r.110. (7) 3 in that the documentation does not include the person who made the order, what device was ordered and any instructions relating to the order. A restraint was applied on residents # 3 and # 16 without a physician's order and instructions relating to the order. Bed rails were applied on resident # 9 without any physician's order. Health care record reviewed by Inspector #161 and there was documented order for the application of a restraint for resident #16.

The licensee has failed to comply with O. Regs 79/10 r.110. (7) 4 in that the documentation does not include consent for the use of physical device restraint. The health care records of resident's # 3 and # 16 were reviewed by Inspectors # 126 and # 161, and no consent was documented for the application of physical restraint.

The licensee has failed to comply with O. Regs 79/10 r.110. (7) 6 in that there is no documentation on assessment, reassessment, monitoring and including resident's response. The health care records for resident's # 3, #9, # 15, # 16 were reviewed by Inspectors #124, #126 and #161 and no documentation on assessment, reassessment, monitoring and including the resident's responses were found. Personal Support Workers #S100, #S101 and #S102 reported to inspector #124 that PSWs apply the residents' restraint and that they do not document regarding restraints.

The licensee has failed to comply with O. Regs 79/10 r.110. (7) 7 in that there is no documentation on the release of the device and repositioning. In July 2012, the health care records for residents #3, # 9, # 15, #16 were reviewed by Inspectors # 161, #124 and #126 and no documentation was found for the release of the device and repositioning of the resident.

The licensee has failed to comply with O. Regs 79/10 r.110. (7) 8 in that there is no documentation on the removal of the device, discontinuance and post restraining care. In July 2012, the health care records for residents # 3, #9, # 15, # 16 were reviewed by Inspectors # 161, #124 and #126 and no documentation was found for the removal of the device, discontinuance and post restraining care.

The licensee has failed to comply with O. Regs 79/10 r.110. (7) 8 in that there is no documentation on the removal of the device, discontinuance and post restraining care.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following subsections:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.

4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 48 (1) in that the licensee did not ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

During a telephone interview in July 2012 with the home's Director of Care, she stated that there is collaboration with the physiotherapy team and that they have tracking indicators.

Discussion with Registered Nurse(RN) #S105 and Registered Practical Nurse(RPN) #S104 indicated that the home has a tracking list for residents who have fallen, including name of resident and date. They are not aware of a fall prevention and management program in the home.

Discussion with staff member #132 stated that if physiotherapy therapy service provider is informed of a resident who has fallen, they will do a monthly analysis to determine if physiotherapy intervention is required.

2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

During a telephone interview in July 2012 with the home's Director of Care, she indicated that there is no skin and wound program.

3. A pain management program to identify pain in residents and manage pain.

During a telephone interview in July 2012 with the home's Director of Care, she stated that there is no pain management program.

Discussion with several Registered Nursing Staff indicated that there is no pain management program

A resident's health care record was reviewed. Physician's order of July 2012, indicated that resident was palliative after returning from the hospital. An analgesic was ordered for 2 weeks.

The resident's Individual Controlled Drug Administration record was reviewed. It did not specify that the analgesic was ordered for 2 weeks. Furthermore, the Registered staff did not know that the analgesic order was for 2 weeks.

The resident's health care record was reviewed. No pain assessment, monitoring or follow-up documented for 6 days.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee had failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 19 (1) in that the licensee did not protect a resident from neglect by the staff by not providing a resident with care, services and assistance required for health, safety and well being which includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of the resident.

Nursing staff members including Registered Nursing staff and Personal Support Workers indicated that a resident was using a transfer pole in the bathroom for independent, safe transfers.

At the beginning of July 2012, renovation of the room and equipment was removed at that time. In July 2012, the resident transferred herself independently in the bathroom without the equipment and fell. The resident sustained an injury.

At that time, an Internal Incident report was completed by Registered Nurse(RN) #S103. Documentation under long term action to be taken indicates: Make sure the equipment is in the bathroom. Information communicated to staff at that time. Discussion with RN #S103 stated that the equipment was reinstalled 2 days after the falls.

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA 2007,S.O. 2007, c.8, s. 84 in that the licensee has not developed and implemented a quality improvement and utilization review system.

In July 2012, the Administrator reported that the home does not have a quality improvement and utilization review system in place; that no performance measures have been identified and that the policies and procedures are based on the Long Term Care Facility Program Manual not the Long Term Care Homes Act 2007 which came into effect July 2010.

In July 2012, the Director of Care reported to inspectors #126, #161 and #124 that the home did not have a falls prevention and management program, skin and wound care program, and pain management program.

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

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

s. 6. (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
(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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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

Findings/Faits saillants :

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

In July 2012, a resident was observed to have a treatment. The resident health care record was reviewed and no documentation, no physican orders or interventions in the pan of care were found related to the treatment.

The resident health care record was reviewed and no documentation was found related to the resident using equipment for transfer. Registered Nurse(RN) #S103 and Registered Practical Nurse(RPN) #S104 stated that they were aware that the resident required a equipment transfer for safety.

The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8 s. 6.(4) (a) in that staff and others involved in the different aspects of care did not collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

In July 2012, a resident was noted to have a restraint that he/she could not undo. The health care record was reviewed and there was no documentation of an assessment for the application of the restraint. Discussion with RN #S103 who indicated that he/she had no idea why the resident had a restraint. Physiotherapist Assistant assessment does not reflect that the resident requires a restraint.

The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8 s. 6.(8) in that staff who provide direct care to residents do not have convenient and immediate access to the resident's plan of care.

PSW's indicated that they do not have access to resident's care plans. The care plans are available electronically however the PSWs have not received any training in order to access residents care plans.

Several resident health care records were reviewed and it was noted that the care plans were printed and out of date i.e. 2010, 2011.

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

Since December 2010, a resident plan of care does not reflect pain management needs and interventions required to provide care. Resident as been administered an analgesic on a regular basis for the last year and no documentation was found on the resident health care record regarding on-going assessment and monitoring of resident's pain. The plan of care as not been reviewed to include that the resident required an analgesic on a regular basis. Registered Practical Nurse #S107 indicated that she was unsure why the resident is receiving an analgesic on regular basis.

A resident was admitted to the home in December 2011. The initial plan of care identified that he/she had sustained a fall in the last thirty days and no interventions to prevent falls were identified. The resident had several falls and his/her plan of care was not revised to include interventions to prevent falls.

Staff #S126 reported that there were no changes to the resident plan of care after the falls until the resident started using a wheelchair. It is documented in the progress notes that the resident was transported by wheelchair in March 2012 after the fall that required the resident to go to hospital.

A resident's Individual Controlled Drug Administration record was reviewed. It did not specify that the analgesic was ordered for 2 weeks. Furthermore, the Registered staff did not know that the analgesic order was for 2 weeks.
The resident's health care record was reviewed. No pain assessment, monitoring or follow-up documented during that period.

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA 2007,S.O. 2007, c.8, s.8 (3) in that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for the regulations.

Staff member #S124 reported to Inspector #124 the following:
On June 23, 24, 28, 30, 2012, day shifts there was no Registered Nurse(RN). An Registered Practical Nurse(RPN) #134 worked those shifts.

On July 4th, there was no RN on duty. An RPN worked the RN shift.

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. As required by O. Reg. 79/10 s.136. (1) (a) the licensee has a policy that provides for the ongoing identification , destruction and disposal of (a) all expired medication. The licensee has failed to ensure that this policy was complied with as demonstrated by the findings below.

The home's policy, "Medication Disposal/Relocation/Recycling" stated that discontinued, unused, expired, recalled, deteriorated, unlabelled drugs or containers with worn, illegible, damaged, incomplete or missing labels will be removed from the current medication supply.

In July 2012 the emergency box was observed to have 16 bottles of medication that had expired and 2 expired injectables (Epenephrine pen and a unlabelled syringe containing brown crystal debris).

In July 2012 observed that the medication fridge located in the medication room has 5 boxes of expired suppositories, 6 expired enteric outbreak sample kits, 3 expired respiratory outbreak sample kits and 1 box of expired Fluad.

In July 2012, during a review of the medication cart, the following expired medications were found:
- A resident had a Nitrolingual pump spray bottle .4mg with an expiry date of June 2012
- A resident had a Nitrolingual pump spray bottle .4mg with an expiry date of January 2012
-A bottle of Micro-K Extencaps, 600mg with an expiry date of October 2009

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 put in place any plan, policy, protocol, procedure, strategy or system is implemented in accordance with all applicable requirements under the Act and complied with., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.
2. An unexpected or sudden death, including a death resulting from an accident or suicide.
3. A resident who is missing for three hours or more.
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 r.107(3)4. in that the licensee did not inform the Director no later than one business day after the occurrence of the incident of an injury in respect of which a person is taken to hospital.

In March 2012, a resident fell and was sent to hospital and the Director was not notified nor was a written report submitted to the Director.

Discussion held with the Administrator and the Director of Care indicated there has not been any Critical Incident Reports sent to the Director since June 2011.
2. The licensee has failed to comply with O. Reg 79/10 r. 107. (1) in that the licensee did not inform the Director in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by a report required in writing to the Director.

In March 2012 a flood occurred in the home and the Director was not notified nor was a written report submitted to the Director.

Discussion held with the Administrator and the Director of Care confirmed that there has not been any Critical Incident Reports sent to the Director since June 2011.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the licensee immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the
report required under subsection (4):

1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.
2. An unexpected or sudden death, including a death resulting from an accident or suicide.
3. A resident who is missing for three hours or more.
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.
6. Contamination of the drinking water supply, and ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. a resident who is missing for less than three hours and who return to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to the hospital.
5.A medication incident or adverse drug restriction in respect of which a resident is taken to the hospital, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s. 129 (1) (a) (ii) to ensure that drugs are stored in an area or a medication cart that is secure and locked

In July 2012 a medication cart in the North hallway was unlocked and staff member # S107 was in a resident's room for approximately 3-4 minutes.

In July 2012 a medication cart in the South Corridor was unlocked and staff member # S107 was in the dining room for approximately 3-4 minutes.

In July 2012, it was observed that there were 5 medication cups each containing 30 mls of lactulose, unlabelled, on the top of a medication cart in the South corridor that was left unattended. Discussion with staff member #S107 who indicated that she should not have prepoured and left the lactulose unattended on the medication cart but did so to help manage workload.

The licensee failed to comply with O. Reg 79/10 s. 129 (1) (a) (iv) in that drugs are stored in an area or a medication cart that complies with manufacturer's instructions for the storage of the drugs.

In July 2012 it was observed that 3 boxes of Prochlorperazine 10 mg suppositories were stored in the medication fridge. The manufacturer's instruction indicated that storage of this medication should be at room temperature.

The licensee has failed to comply with O. Reg 79/10 s. 129 (1) (b) 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.

In July 2012 the Director of Care indicated that discontinued narcotics are stored in a locked plastic toolbox which is hidden in her office and not double-locked. She shares her office with three other staff members.

In July 2012 the inspector located the discontinued narcotic box on the floor, in the corner of the Director of Care's office, adjacent to a bookcase. The box was not double-locked.

In July 2012 it was observed a yellow unlocked plastic box sitting on the floor in the medication room. It contained 25 vials of narcotics injectable.

In July 2012 it was observed that in resident's medication bin located within the medication cart, that Diazepam a controlled substance was not double locked.

In July 2012, the following controlled substances were observed in several resident's medication bin within the medication cart and Lorazepam and Diazepam were not double locked.

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 drugs are stored in an area or medication cart that is used exclusively for drugs and drug-related supplies, that is secure and locked,that complies with manufacturer's instructions for the storage of the drugs; and 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 #10: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, s. 131 (1) in that the licensee did not ensure that a drug is administered to a resident in the home unless the drug has been prescribed for the resident.

In July 2012 a bottle of Vitamin C for a resident labelled "Placebo" was observed in the fourth drawer of the medication cart.
A review of the resident's health record indicated that Vitamin C had not been prescribed for the resident.

The licensee has failed to comply with O.Regs 79/10 r 131. (2) in that the licensee did not ensure that drugs are administered to the resident in accordance with the directions for use specified by the prescriber.

In July 2012 during the morning medication pass, it was observed that a resident received an oral diabetic medication at 09:54. The resident's health record was reviewed and an oral diabetic medication is prescribed twice a day at 08:00 and 17:00. Discussion held with staff member #105 stated that the administration the oral diabetic medication should be at 08:00 and 17;00 unless indicated otherwise by the physician. The resident's Electronic Medication Administration Record (E-Mar) was reviewed for the last 5 days. The oral diabetic medication was administered on:
July 26, 12 (09:54 am)
July 25, 12 (09:16 am)
July 24, 12 (09:51 am)
July 23, 12 (09:20 am)
July 22, 12 (09:33 am)

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 drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident and to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber., to be implemented voluntarily.

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

Specifically failed to comply with the following subsections:

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

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

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 s.229.(10) 1. in that each resident admitted to the home was not screened for tuberculosis within 14 days of admission.

A Resident was admitted to the home in October 2011. It is documented in the Mantoux Record Book that the first step of his/her Mantoux screening was administered 58 days after admission.

A resident was admitted to the home in February 2012. It is documented in the Mantoux Record Book that the first step of his/her Mantoux screening was administered 46 days after admission.

The licensee failed to comply with O. Reg. 79/10 s.229. (10) 3. in that the residents are not offered immunizations against tetanus and diphtheria as demonstrated by the following findings.

In July 2012, the Director of Care reported that the home does not offer residents immunization against tetanus and diphtheria.

The health care records for several residents were reviewed and there was no documentation to indicate that the residents have not been immunized against tetanus and diphtheria.

The licensee failed to comply with O.Reg. 79/10 s.229. (10) 4. in that staff are not screened for tuberculosis and other infectious diseases in accordance with evidence-based practices.

In July 2012, the Director of Care reported to the inspector that the staff are not screened for tuberculosis.

The licensee failed to comply with O.Reg.79/10 s. 229. (10) 5. in that there is not a staff immunization program in place in accordance with evidence-based practices with regard to diphtheria and tetanus.

In July 2012, the Director of Care reported that there is not a staff immunization program in place for diphtheria and tetanus.

The licensee failed to comply with O. Reg. 79/10 s. 229. (12) in that the pet visiting as part of the pet visitation program did not have up-to-date immunizations.

The Director of Activation reported that every Tuesday afternoon, staff member #S131 brings her dog to the home to visit the residents.

Staff member S#131 reported to inspector that her dog's immunizations were not up to date.

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 immunization and screen measures are in place for tuberculosis, tetanus, diphtheria including screening for residents and staff and that the immunization program is in accordance with evidenced-bases practices and if there are none , in accordance with prevailing practices., to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15 (2) (a) in that the furnishings and equipment are kept clean.

Throughout this inspection it was observed in the small dining room that the tables, chairs, window tracks had food crumbs and other debris on them.

Throughout this inspection it was observed that two mechanical lifts had dusty appearing debris on them.

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

In July 2012 an inspector sat down on a chair adjacent to the nursing station. The chair collapsed and the inspector fell to the concrete floor. A subsequent investigation revealed an "out of order" note that was located under the seat of the chair.

Throughout the inspection it was observed in the South Dining room there were two stained tables, finish worn on the table legs, paint chipped. Main lounge chairs have finish worn on chair legs, walls missing paint, white plaster evident, and cable socket exposed. Resident room door frames have chipped paint, cupboards in resident rooms are scratched, gouged and have chipped paint.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's furnishings and equipment are kept clean and maintained in a safe condition and in a good state of repair., to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 53 (1)1. 2. 3. in that the following have not been developed to meet the needs of residents with responsive behaviours:

1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

3. Resident monitoring and internal reporting protocols.

On July 24, 2012 the Director of Care reported to inspectors# 124, # 126, # 161 that there are not written approaches to care, written strategies nor resident monitoring and internal reporting protocols developed to meet the needs of residents with responsive behaviours.

Discussion with Registered Nurses # S103 and # S105 who indicated that they were unaware of written approaches to care, written strategies nor resident monitoring and internal reporting protocols developed to meet the needs of residents with responsive behaviours.

A Resident health record was reviewed. There were no written approaches to care, written strategies nor resident monitoring and internal reporting protocols developed to meet the needs of this resident with responsive behaviours.

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 written approaches, strategies, resident monitoring and internal reporting and referral to specialized resources protocol are developed to meet the needs of residents with responsive behaviors, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 86. Accommodation services programs

Specifically failed to comply with the following subsections:

s. 86. (3) The licensee shall ensure that there are written policies and procedures to monitor and supervise persons who provide occasional maintenance or repair services to the home pursuant to the agreement referred to in subsection (2). O. Reg. 79/10, s. 86 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s. 86 (3) in that there are no written policies and procedures to monitor and supervise persons who provide occasional maintenance or repair services to the home pursuant to the written agreement in r. 86 (2).

In July 2012 the home's Administrator indicated that the home does not have written policies and procedures to monitor and supervise persons who provide occasional maintenance or repair services to the home.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 123. Emergency drug supply
Every licensee of a long-term care home who maintains an emergency drug supply for the home shall ensure,
(a) that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator are kept;
(b) that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply;
(c) that, at least annually, there is an evaluation done by the persons referred to in clause (a) of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs; and
(d) that any recommended changes resulting from the evaluation are implemented. O. Reg. 79/10, s. 123.

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 123(a) in that the emergency drug supply for the home does not contain a list of approved drugs for this purpose by the Medical Director.

No clinical documentation to indicate an approved list of drugs for the emergency drug supply for the home that have been approved for this purpose by the Medical Director.

Discussion with registered staff member #S104 and #S105 who indicated that they did not know what drugs were to be in the emergency drug supply box.

Discussion with home's Administrator who indicated that there is no evidence to suggest that the Medical Director has approved the drugs contained in the emergency drug supply.

WN #16: 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 subsections:

s. 59. (1) Every long-term care home may have a Family Council. 2007, c. 8, s. 59. (1).

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
(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 failed to comply with O. Reg 79/10 s. 59 (7) (b) in that the licensee did not convene semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council.

In July 2012 during the entrance conference of the Resident Quality Inspection, the Administrator indicated to Inspector #126 that a Family Council had not been established.

In July 2012 the home's Administrator indicated that in 2012 the licensee did not convene a semi-annual meeting to advise residents' families and persons of importance to residents of their right to establish a Family Council.

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

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.79. (3) (c) in that the policy to promote zero tolerance of abuse and neglect of residents is not posted.

In July 2012, discussion held with staff member #S124, who indicated that the home's policy to promote zero tolerance of abuse and neglect of residents is provided in the Information Booklet given on admission to newly admitted residents but the policy is not posted in the home.

The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.79. (3) (e) in that the procedures for initiating complaints to the licensee is not posted.

In July 2012, discussion staff member #S124 indicated that the procedure for initiating a complaint is provided in the Information Booklet given on admission to newly admitted residents but the procedure is not posted in the home.

The licensee has failed to comply with LTCHA 2007, S.O. 2007, C.8, s.79. (3) (g) in that the policy to minimize the restraining of the resident is not posted.

In July 2012, Inspector #126 unable to locate the posting of the policy to minimize the restraining of the resident.

In July 2012, discussion held with staff member #S117, confirmed that the policy to minimize the restraining of residents is not posted

The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.79. (3) (h) in that the telephone number of the licensee not posted.

In July 2012, discussion held staff member #S124 who indicated that the telephone number of the licensee is provided in the Information Booklet given on admission to newly admitted residents but the telephone number of the licensee is not posted in the home.

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 subsections:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s.73 1(7) in that there was not sufficient time provided for a resident to eat at their own pace.

During the Inspector's observation of the morning medication pass in July 2012, a resident indicated to staff member #S113 that he/she was upset because he/she did not have his/her breakfast. The resident attempted to enter the dining room for breakfast. He/she was told by a staff member to go and eat his/her breakfast in the activity room as they needed the dining room empty to clean it. At that time in the Activity room, there were approximately 15 residents singing, watching television and/or exercising. The resident refused to have his/her breakfast in that room at it was too noisy and loud.

In July 2012 it was observed by Inspectors #126 and #161 that a resident was in the Activity room having his/her breakfast.

Discussion with staff member #S133 indicated that the home offers breakfast twice, the first at 08:00 and the second between 08:45-09:00. If residents are not finished their breakfast by 09:00, the residents are transferred to the activity room to finish eating their breakfast.

Discussion held with staff member #S101 who stated that they are expected to have the residents out of the dining room by 09:00.

Discussion with staff member #S116 who stated that the residents need to be out of the dining room at around (08:50-09:00) so that staff can wash the dining room before lunch. She stated that if the residents have not finished eating their breakfast, they are transferred to the activity room to finish eating their breakfast.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following subsections:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Regs 79/10 r.49.(2) in that the residents who fell were not assessed post-fall using a clinically appropriate assessment instrument that is specifically designed for falls.

A resident fell on several occasions in March 2012 and each time his/her physical status post fall assessment was documented in the progress notes. There was no evidence of use of a clinically appropriate assessment instrument that is specifically designed for falls.

A resident fell in April and July 2012 and no post-fall assessment was conducted.

A resident fell in July 2012 and no post-fall assessment was conducted. Staff member # S104 stated that they did not do a post fall assessment on resident #5.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following subsections:

s. 241. (1) Every licensee of a long-term care home shall establish and maintain at least one non-interest bearing trust account at a financial institution in which the licensee shall deposit all money entrusted to the licensee's care on behalf of a resident. O. Reg. 79/10, s. 241 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10 s. 241 (1) in that all money entrusted to the licensee's care on behalf of a resident was not deposited in the non-interest bearing trust account as evidenced by the following findings:

The Administrator reported that the home does not have a non-interest bearing account established at a financial institution. As a result, money entrusted to the licensee's care on behalf of the residents has not been deposited in a non -interest bearing trust account as per regulation.

Staff member # S125, reported that the home has managed the resident funds entrusted to them through a pin money system. As part of the pin money system, each resident has an envelope where their funds are stored and an individual record on the envelope that details the deposits and withdrawals to the pin money envelope. These envelopes are kept in the home.

Staff member #S124, reported that there are two cheques for a resident in the amounts of $100 and $131, awaiting the establishment of the trust account. These cheques are kept locked in a drawer in the front office.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10 s. 17. (1) (a) in that the resident's communication response system could not be easily accessed and used by the resident.

In July 2012, a resident was observed sitting in his/her chair in her room. It was observed that his/her call bell was clipped to his/her bed and he/she was unable to reach the call bell.

In July 2012, a resident's call bell was on his/her bedside table and the resident demonstrated that he/she was unable to reach his/her call bell.

On July 2012, in resident's bathroom, there was not a pull cord attached to the emergency call bell.

WN #22: 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 subsections:

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 failed to comply with O.Reg. 79/10 s.31. (2) in that there is no written staffing plan for the nursing and personal support services programs.

In July 2012, the Administrator reported that to the best of his knowledge there is no written staffing plan in place at Hilltop Manor.

In July 2012, Registered Nurse #S105 reported that there is no written protocol that addresses situations when staff cannot come to work, a requirement of the written staffing plan.

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

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.85 (1) in that an annual satisfaction survey of residents and their families was not conducted.

In July 2012, the President of Resident's Council indicated that the licensee did not conduct a satisfaction survey in 2011.

Staff member #S123 stated there was no satisfaction survey of residents and their families conducted in 2011.

The Administrator stated that a satisfaction survey of residents and families was not conducted in 2011.

WN #24: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following subsections:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) in that not all staff of the home have received training as required before performing their responsibilities.

The Director of Care and the Administrator reported that the general orientation was conducted by the former Administrator and the completed orientation checklists would be filed on the staff Human Resource records.

Staff members that worked their first shift in January and February 2011 received their general orientation in February 2011.

A staff member that was hired in July 2011; had no orientation checklist on the HR file and no record of general orientation.

Staff members that were hired in February, in June and in September 2011 and in June and September 2012 and there was no orientation checklist on file.

Two staff members, reported to the inspector that they had not received general orientation.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Issued on this 14th day of August, 2012

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

L Hawkins

Kathleen Enid

Lynda Hamilton

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

Ministère 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) :	LINDA HARKINS (126), KATHLEEN SMID (161), LYNDA HAMILTON (124)
Inspection No. / No de l'inspection :	2012_039126_0001
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Date of Inspection / Date de l'inspection :	Jul 11, 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 31, Aug 1, 2, 3, 7, 8, 9, 10, 13, 2012
Licensee / Titulaire de permis :	HILLTOP MANOR NURSING HOME LIMITED 82 Colonel By Crescent, Smiths Falls, ON, K7A-5B6
LTC Home / Foyer de SLD :	HILLTOP MANOR NURSING HOME LIMITED 1005 ST LAWRENCE STREET, P.O. BOX 430, MERRICKVILLE, ON, K0G-1N0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~PETER GRAIE~~ JIM PARSONS

To HILLTOP MANOR NURSING HOME LIMITED, 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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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:

1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Order / Ordre :

110. (7) The 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 registered nursing staff complete an immediate audit of all residents in a restraining device
- ensure that an assessment, reassessment and monitoring, including the resident's response are documented and physician orders and consent are obtained.

Grounds / Motifs :

1. 1. The licensee has failed to comply with O.Reg 79/10 r.110 (7) 1 in that the documentation does not include the circumstances precipitating the application of the physical device.

In July 2012, resident # 16 was noted to have a restraint that he/she could not undo. Staff members # 104 and # S105 reported to Inspector #126 that they did not know why the resident had a restraint.Resident # 16's health care record was reviewed by Inspector #126 and there was no documentation of any assessment completed for the application of the restraint.

The licensee has failed to comply with O.Regs 79/10 r.110. (7) 3 in that the documentation does not include the person who made the order, what device was ordered and any instructions relating to the order. A restraint was applied on residents # 3 and # 16 without a physician's order and instructions relating to the order. Bed rails were applied on resident # 9 without any physician's order. Health care record reviewed by Inspector #161 and there was documented order for the application of a restraint for resident #16.

The licensee has failed to comply with O. Regs 79/10 r.110. (7) 4 in that the documentation does not include consent for the use of physical device restraint. The health care records of resident's # 3 and # 16 were reviewed by Inspectors # 126 and # 161, and no consent was documented for the application of physical restraint.

The licensee has failed to comply with O. Regs 79/10 r.110. (7) 6 in that there is no documentation on assessment, reassessment, monitoring and including resident's response. The health care records for resident's # 3, #9, # 15, # 16 were reviewed by Inspectors #124, #126 and #161 and no documentation on assessment, reassessment, monitoring and including the resident's responses were found. Personal Support Workers #S100, #S101 and #S102 reported to inspector #124 that PSWs apply the residents' restraint and that they do not document regarding restraints.

The licensee has failed to comply with O. Regs 79/10 r.110. (7) 7 in that there is no documentation on the release of the device and repositioning. In July 2012, the health care records for residents #3, # 9, # 15, #16 were reviewed by Inspectors # 161, #124 and #126 and no documentation was found for the release of the device and repositioning of the resident.

The licensee has failed to comply with O. Regs 79/10 r.110. (7) 8 in that there is no documentation on the removal of the device, discontinuance and post restraining care. In July 2012, the health care records for residents # 3, #9, # 15, # 16 were reviewed by Inspectors # 161, #124 and #126 and no documentation was found for the removal of the device, discontinuance and post restraining care.

The licensee has failed to comply with O. Regs 79/10 r.110. (7) 8 in that there is no documentation on the removal of the device, discontinuance and post restraining care. (126)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 14, 2012

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The license shall prepare, submit and implement a plan for achieving compliance to ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

This plan must be submitted to Linda Harkins, Long Term Care Home Inspector, Ottawa, SAO by August 20, 2012 via fax # (613) 569-9670.

Grounds / Motifs :

1. 1. The licensee has failed to comply with O. Reg 79/10 s. 48 (1) in that the licensee did not ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

During a telephone interview in July 2012 with the home's Director of Care, she stated that there is collaboration with the physiotherapy team and that they have tracking indicators.

Discussion with Registered Nurse(RN) #S105 and Registered Practical Nurse(RPN) #S104 indicated that the home has a tracking list for residents who have fallen, including name of resident and date. They are not aware of a fall prevention and management program in the home.

Discussion with staff member #132 stated that if physiotherapy therapy service provider is informed of a resident who has fallen, they will do a monthly analysis to determine if physiotherapy intervention is required.

2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

During a telephone interview in July 2012 with the home's Director of Care, she indicated that there is no skin and wound program.

3. A pain management program to identify pain in residents and manage pain.

During a telephone interview in July 2012 with the home's Director of Care, she stated that there is no pain management program.

Discussion with several Registered Nursing Staff indicated that there is no pain management program

A resident's health care record was reviewed. Physician's order of July 2012, indicated that resident was palliative after returning from the hospital. An analgesic was ordered for 2 weeks.

The resident's Individual Controlled Drug Administration record was reviewed. It did not specify that the analgesic was ordered for 2 weeks. Furthermore, the Registered staff did not know that the analgesic order was for 2 weeks.

The resident's health care record was reviewed. No pain assessment, monitoring or follow-up documented for 6 days. (124)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 12, 2012

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all residents of a long-term care home shall be protected from neglect by providing care, services and assistance required for health, safety and well being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of the resident.

Grounds / Motifs :

1. 1. The licensee had failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 19 (1) in that the licensee did not protect a resident from neglect by the staff by not providing a resident with care, services and assistance required for health, safety and well being which includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of the resident.

Nursing staff members including Registered Nursing staff and Personal Support Workers indicated that a resident was using a transfer pole in the bathroom for independent, safe transfers.

At the beginning of July 2012, renovation of the room and equipment was removed at that time. In July 2012, the resident transferred herself independently in the bathroom without the equipment and fell. The resident sustained an injury.

At that time, an Internal Incident report was completed by Registered Nurse(RN) #S103. Documentation under long term action to be taken indicates: Make sure the equipment is in the bathroom. Information communicated to staff at that time. Discussion with RN #S103 stated that the equipment was reinstalled 2 days after the falls. (126)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 14, 2012

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that the home develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to the residents of the long-term care home.
This plan must be submitted to Linda Harkins, Long Term Care Inspector, Ottawa SAO by August 20, 2012 via fax # (613) 569-9670.

Grounds / Motifs :

1. The licensee failed to comply with the LTCHA 2007,S.O. 2007, c.8, s. 84 in that the home has not developed and implemented a quality improvement and utilization review system.

On July 19, 2012, the Administrator reported that the home does not have a quality improvement and utilization review system in place; that no performance measures have been identified and that the policies and procedures are based on the Program Manual not the Long Term Care Homes Act 2007 and O. Reg 79/10, 2007.

On July 24, 2012, the Director of Care reported to inspectors #126, #161 and #124 that the home did not have a falls prevention and management program, skin and wound care program,and pain management program. (124)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 12, 2012

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and any other time when the resident's care needs change or the care set out in the plan is no longer necessary.

This plan must be submitted to Linda Harkins, Long Term Care Homes Inspector, Ottawa Service Area Office (OSAO) by August 20, 2012, via fax # (613) 569-9670.

Grounds / Motifs :

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

Since December 2010, a resident plan of care does not reflect pain management needs and interventions required to provide care. Resident as been administered an analgesic on a regular basis for the last year and no documentation was found on the resident health care record regarding on-going assessment and monitoring of resident's pain. The plan of care as not been reviewed to include that the resident required an analgesic on a regular basis. Registered Practical Nurse #S107 indicated that she was unsure why the resident is receiving an analgesic on regular basis.

A resident was admitted to the home in December 2011. The initial plan of care identified that he/she had sustained a fall in the last thirty days and no interventions to prevent falls were identified. The resident had several falls and his/her plan of care was not revised to include interventions to prevent falls.

Staff #S126 reported that there were no changes to the resident plan of care after the falls until the resident started using a wheelchair. It is documented in the progress notes that the resident was transported by wheelchair in March 2012 after the fall that required the resident to go to hospital.

A resident's Individual Controlled Drug Administration record was reviewed. It did not specify that the analgesic was ordered for 2 weeks. Furthermore, the Registered staff did not know that the analgesic order was for 2 weeks.
The resident's health care record was reviewed. No pain assessment, monitoring or follow-up documented during that period. (126)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 01, 2012

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

This plan must be submitted to Linda Harkins, Long Term Care Home Inspector, Ottawa, SAO by August 20, 2012 via fax # (613) 569-9670.

Grounds / Motifs :

1. Staff member #S124 reported to Inspector 124 the following:
On June 23, 24, 28, 30, 2012, day shifts there was no Registered Nurse(RN). An Registered Practical Nurse (RPN) #134 worked those shifts.

On July 4th, there was no RN on duty. An RPN worked the RN shift, (126)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 01, 2012

Ontario

Ministry of Health and Long-Term Care

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

Ministère 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

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

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

and the

Director

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.

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

Ministère 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

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 :

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

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
Toronto ON M5S 2B1
Télécopieur: (416) 327-7603

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

Issued on this 13th day of August, 2012

Signature of Inspector / Signature de l'inspecteur : L Harkins Kathleen Smid / Lynda Hamilton

Name of Inspector / Nom de l'inspecteur : LINDA HARKINS

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

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

	☐ Licensee Copy/Copie du Titulaire	X Public Copy/Copie Public	
Name of Inspector:	Linda Harkins	**Inspector ID #**	126
Log #:	O-001592-12		
Inspection Report #:	2012-036126-0016		
Type of Inspection:	Resident Quality Inspection		
Date of Inspection:	July 11, 2012		
Licensee:	Hilltop Manor Nursing Home Limited 82 Colonel By Crescent Smith Falls, ON, K7A 5B6		
LTC Home:	Hilltop Manor Nursing Home Limited 1005 St Lawrence Street P.O. Box 430 Merrickville, ON, K0G 1N0 Fax: (613) 269-3534		
Name of Administrator:	James Parsons		

To HILLTOP MANOR NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order #:	901	**Order Type:**	Compliance Order, Section 153 (1) (a)

Pursuant to / Aux Termes de:

O.Reg 79/10, s. 130. 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, prescribed 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.

Order / Ordre :

The licensee shall ensure that steps are taken to ensure the security of the drug supply is restricted to the persons who may dispense, prescribe or administer drugs in the home and the Administrator.

Grounds / Motifs :

- The licensee failed to comply with O.Reg 79/10, s. 130 (2) in that the licensee did not ensure that steps were taken to ensure the security of the drug supply is restricted to the persons who may dispense, prescribe or administer durgs in the home, and the Administrator
- On July 11, 2012, at approximately 12:15pm, it was noted by inspector #126, that the home's medication room doors were open and that a construction worker was in the medication room doing renovations without the supervision of persons who may dispense, prescribed or administer drugs, or the Administrator. (126)

This order must be complied with by: Vous devez vous conformer à cet ordre d'ici le:	Immediate

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 service 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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
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.

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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
Toronto ON M5S 2B1
Télécopieur: (416) 327-7603

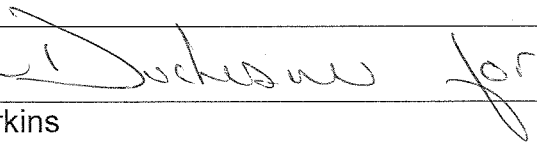
Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur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

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

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

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

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter l'appel. Les titulaires depermis 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 11th day of July, 2012.	
Signature of Inspector:	
Name of Inspector:	Linda Harkins
Service Area Office:	Ottawa