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
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Date(s) of Inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Feb 17, 19, 21, 22, 23, 24, 27, 28, 29, Mar 1, 2, 3, 5, 6, 7, 8, 12, 13, 14, 15, 16, 19, 20, 21, 22, 27, 2012	2012_087128_0005	Resident Quality Inspection

Licensee/Titulaire de permis

SHARON FARMS & ENTERPRISES LIMITED
1340 HURON STREET, LONDON, ON, N5V-3R3

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

KENSINGTON VILLAGE
1340 HURON STREET, LONDON, ON, N5V-3R3

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

RUTH HILDEBRAND (128), BONNIE MACDONALD (135), PEGGY SKIPPER (160), SANDRA FYSH (190)

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, Assistant Administrator, Director of Nursing Care (Acting), Assistant Director of Nursing Care (Acting), Director of Dietary Services, Dietary Services Supervisor, Director of Environmental Services, Director of Activation and Volunteer Services, Front Receptionist, RAI-MDS/Restorative Care Coordinator, 4 Registered Nurses, 9 Registered Practical Nurses, 20 Personal Support Workers (PSW), 1 Health Care Aide, 1 Physiotherapist, 1 Physiotherapy Assistant, 2 Cooks, 6 Dietary Aides, 2 Housekeeping Aides, 1 Maintenance Worker, 2 Recreation Aides, 1 Residents' Council Volunteer Assistant, 1 Residents' Council representative, 8 Family Members and 43 Residents.

During the course of the inspection, the inspector(s) conducted a tour of all resident areas and common areas, observed residents and the care provided to them, and observed meal service. Medication administration was observed and the clinical records for identified residents were reviewed. The inspectors reviewed admission and resident charges records, policies and procedures, as well as minutes of meetings pertaining to the inspection.

Log # L-000220-12

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

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

Snack Observation

Sufficient Staffing

Trust Accounts

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

s. 6. (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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. A record review confirmed an identified resident's plan of care did not have an assessment of his/her sleep preferences or sleep patterns.
An interview with the RAI Co-ordinator confirmed that the resident has not had an interdisciplinary assessment for sleep preferences or sleep patterns.
[LTCHA, 2007 S.O. 2007, c.8, s. 6 (2)]
2. A record review confirmed that the current plan of care does not reflect a comprehensive interdisciplinary assessment or identify the resident-specific preferences and interests voiced by an identified resident.
The Activation Manager confirmed there was little interdisciplinary involvement or comprehensive assessment in the development of the resident's plan of care.
[LTCHA, 2007 S.O. 2007, c.8, s. 6 (2)]
3. A review of the resident record for an identified resident revealed that 27 days after admission, the plan of care on the computer lists 3 foci:
- risk of falls with interventions
- alteration in supervised/organized recreation with interventions
- supervision with eating with interventions
There are no identified pain issues on the plan of care, nor interventions to deal with pain control.
A Personal Support Worker was questioned about what he/she would do if a resident had pain. He/she indicated that he/she would report it to the nurse at the desk or the nurse doing medications. When asked about directions or instructions about the care of a resident, specifically about pain relief, he/she stated that it would likely be on the care plan.
The RAI Coordinator confirmed that a plan of care specifically regarding pain control and interventions has not been developed for the identified resident even though the initial pain assessment and ongoing progress notes indicate that the resident is experiencing significant pain.
It was also noted on the dietary profile that the resident had an allergy/intolerance to peanuts and clear direction was not provided to staff and others who provide direct care. This allergy was not listed in the allergy section on Point Click Care, nor was it noted on the paper chart.
When questioned, a Registered Nurse on duty was not aware that the resident had an allergy.
[LTCHA, 2007 S.O. 2007, c.8, s.6 (1)(c) and 6 (2)]
4. A record review confirmed an identified resident's plan of care did not have an assessment of sleep preferences or sleep patterns, preferred time in the morning to rise nor bathing preferences.
A Personal Support Worker confirmed that this information should be on the plan of care but he/she said he/she had no idea whether it was there or not.
The RAI Coordinator confirmed to Inspector #135 that all residents sleep preferences would not be documented as she was not familiar with the LTCHA.
[LTCHA, 2007 S.O. 2007, c.8, s. 6 (2)]
5. A clinical record review for an identified high risk resident revealed that neither a reassessment nor plan of care revision were done when the care needs changed related to ongoing weight loss and poor oral intake.
A record review confirmed the resident's average food and fluid intake was less than 25 % at meals and snacks. His/her weight loss as of February 1, 2012 was 5.4%.
A Personal Support Worker confirmed that the resident had not been eating well for two or more weeks.
A Dietary Aide serving in a dining room indicated that the resident had not been eating well for the last month and the Registered Nursing staff had been trialing a texture modified diet but the resident continued to spit out the food. The Dietary Aide confirmed the diet list indicates the resident is to get a regular diet and regular texture.
The resident was observed receiving a texture modified diet and had an intake of less than 25 %, on March 2, 2012.
The Registered Dietitian confirmed she was not aware that the resident's care needs had changed related to poor intake and weight loss as the resident had not been referred for a change in nutritional status until February 27, 2012.
[LTCHA, 2007 S.O. 2007, c.8, s. 6 (10) b]
6. An identified resident confirmed that he/she has not had an opportunity to participate in the development of his/her plan of care, specifically interventions for pain relief.
The plan of care includes information related to physiotherapy, risk for falls, recreation and diagnosis-related interventions. It does not address pain, nor does the plan of care address activities of daily living such as bathing, mobility, toileting or personal hygiene.
A Personal Support Worker confirmed that the plan of care the staff would access to learn about this resident's needs or preferences would be on Point of Care. He/she also confirmed that there is no information on this resident's plan of care

to indicate how pain is addressed. He/she confirmed that the resident's information related to bathing, mobility, toileting or personal hygiene are not available on the plan of care.
The RAI Coordinator confirmed that the plan of care for the resident does not identify a focus for pain control and does not address interventions for pain control to guide staff in providing care.
[LTCHA, 2007 S.O. 2007, c.8, s. 6 (2), 6 (5) and 6 (8)]
7. Two daughters of an identified resident revealed that the current recreational and social activities offered are no longer effective in meeting the resident's needs and interests with quality of life, related to a recent decline in cognitive and physical status. Different approaches have not been considered with family input to determine options.
The Activation Manager confirmed that the activation program currently does not have a process in place to re-assess residents recreation and social needs or interests, and does not have a process for monitoring the level of participation with activities.
A review of the identified resident's current activation plan of care, which was last updated in 2010 indicates that it was not based on an interdisciplinary assessment of the resident's activity pattern and pursuits and that the goals that have not been re-assessed to identify the resident's current interest and needs related to a decline in cognitive and physical status.
The Activation Manager confirmed the need to re-assess the resident using an interdisciplinary assessment and establish a plan with consideration for different approaches that will more effectively provide enjoyment and improved quality of life.
[LTCHA, 2007 S.O. 2007, c.8, s. 6 (2) and 6 (11)(b)]
8. A record review confirmed that the current plan of care does not reflect a comprehensive interdisciplinary assessment or identify the resident-specific preferences and interests voiced by an identified resident. He/she stated that he/she will attend but is not interested in many activities offered at the home, and would enjoy more outings for shopping, stating the home has reduced the outings previously offered and that he/she would like to play bingo at a bingo hall.
The plan of care has not been reviewed and revised since 2010. The care set out in the plan has not been effective, and different approaches have not been considered.
The Activation Manager confirmed there was little interdisciplinary involvement or comprehensive assessment in the development of the resident's plan of care and she confirmed the goals have not been met and or re-assessed to identify the resident's current interest and needs. She also confirmed the need to include goals to support the development and determination of leisure/recreation choices, that are appropriate for the resident, through the next quarter and to offer activity programs that are directed towards this resident's specific needs and interests.
[LTCHA, 2007 S.O. 2007, c.8, s. 6 (1)(c)]
9. A lunch meal was observed in a dining room and it was noted that an identified resident was served a diet not in keeping with the nutritional plan of care.
A Dietary aide serving lunch confirmed, the resident was served an incorrect diet.
The Director of Dietary Services confirmed her expectation that the resident be provided the correct diet as per the resident's nutritional plan of care.
[LTCHA, 2007 S.O. 2007, c.8, s. 6 (7)]
10. A clinical record review revealed that an identified resident has not been reassessed and the plan of care reviewed and revised when the resident's continence care needs changed.
The Director of Care confirmed that the expectation is that registered staff conduct re-assessment of residents continence care needs when care needs change, and confirmed that a re-assessment should have been done to address the changed continence care needs.
[LTCHA, 2007 S.O. 2007, c.8, s. 6 (10)(b)]
11. A clinical record review was completed for an identified resident to determine if a reassessment and plan of care revision were completed after a return from hospital. The plan of care has not been updated since the resident returned from hospital.
The RAI Coordinator was questioned about the expectations regarding reassessment and care plan revision when a resident has a change of condition upon return from hospital. She confirmed that the expectation is that the Registered staff person doing the readmission would be responsible for completing the care plan revisions.
[LTCHA, 2007 S.O. 2007, c.8, s. 6 (10) b]
12. A record review revealed that the plan of care does not provide information regarding the preferred rising or bedtime preferences of an identified resident.
A Personal Support Worker stated that if they require information regarding a resident's preferences, they would refer to the resident's plan of care for this information.

[LTCHA, 2007 S.O. 2007, c.8, s. 6 (2)]
13. A record review revealed that an identified resident had a specialized diet order.
The Registered Dietitian confirmed that care was not provided as specified in the resident's nutritional plan of care.
[LTCHA, 2007 S.O. 2007, c.8, s. 6 (7)]

Additional Required Actions:

CO # - 001, 006 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. 25. Initial plan of care

Specifically failed to comply with the following subsections:

s. 25. (1) Every licensee of a long-term care home shall ensure that,
(a) the assessments necessary to develop an initial plan of care under subsection 6 (6) of the Act are completed within 14 days of the resident's admission; and
(b) the initial plan of care is developed within 21 days of the admission. O. Reg. 79/10, s. 25 (1).

Findings/Faits saillants :

1. Record reviews confirmed that the initial MDS assessments for twelve residents were incomplete. None of these residents had the initial required assessment completed within 14 days of admission so that the initial plan of care could be developed within 21 days of admission.
It was confirmed during an interview with the Director of Care and the RAI Coordinator that they were both aware that these assessments had not been completed and subsequently that plans of care had not been developed for all of these newly admitted residents. However, no further action was taken.
[O.Reg. 79/10, s. 25 (1) (a) and (b)]
2. An identified resident did not have an initial MDS assessment, including the pain portion of the assessment completed, despite the fact that he/she was receiving pain medication four times daily.
There are no interventions for pain noted on the plan of care for this resident.
[O.Reg. 79/10, s. 25 (1)]

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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. A review of the quality improvement program revealed that the home was unable to demonstrate 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.
Additionally, there is no evidence to support that there are screening protocols and assessment and reassessment instruments in place for these programs.
The Administrator acknowledged during an interview, on March 1, 2012, that he could not confirm these programs were in place.
The Director of Care revealed to the inspection team that the home does not have a comprehensive program developed and implemented for Falls Prevention and Management, Skin and Wound Care, Continence Care and Bowel Management and Pain Management.
[O.Reg. 79/10, s. 30 (1) 1] (135) (160) (190)

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 O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. During a record review it was noted that an identified resident had a weight loss of 3.5 kgs. (5.4%)in one month and was not assessed using an interdisciplinary approach, nor were actions taken for the weight loss greater than 5 % in one month.
During a record review it was noted that an identified resident had a weight loss of 3.9 kgs. (6.8%) in one month and was not assessed using an interdisciplinary approach, nor were actions taken for weight loss greater than 5% in one month.
The Registered Dietitian confirmed that both residents had not been assessed nor were actions taken for either weight loss of 5% or more in one month.
[O. Reg.79/10, s. 69.1.]
2. A record review revealed an identified resident had a weight loss of 5.5 kgs. (8%) since November 2011 and was not assessed using an interdisciplinary approach, nor were actions taken for the weight loss greater than 7.5 % in three months.
The Registered Dietitian confirmed the resident had not been assessed nor were actions taken for the resident's weight loss of 7.5% or more in three months.
[O.Reg.79/10,s.69.2.]

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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following subsections:

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

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

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. Infection control risks were observed in ten shared resident rooms as well as spa/tub rooms including:
-unlabelled personal care items including combs, hair and tooth brushes, denture cups, nail clippers, a nail file, cuticle trimmers, scissors, bed pans, urinals, urine collection hats, deodorant, personal skin care and hair products;
-improperly stored items sitting on bathroom floors or bathroom counters or backs of toilets including clean briefs, wash basins, bed pans, urinals, and urine collection hats.

Evidence of lack of hand washing/hand hygiene, as well as improper glove use, was observed as evidenced by:
During a lunch meal, in a dining room, handwashing/hand hygiene was not observed between handling dirty dishes and serving residents meals, by staff.
A PSW was observed exiting from a resident's room that had infection control precautions in place. This PSW was wearing gloves and proceeded to move the lift down the hall, stop and pick up clean linen with his/her gloved hands, and did not discard the gloves prior to entering another resident room.

During an interview with the Infection Control Officer/Director of Care the following expectations were confirmed:
a) Both registered and non-registered staff must wash their hands or use hand sanitizer after handling dirty dishes before serving residents their meals in the dining room.
b) Personal care equipment, including urinals, urine collection hats, bed pans, wash basins and nail clippers are to be cleaned, disinfected and stored properly after each use.
c) Combs, hair and tooth brushes, deodorant and personal skin care products are to be labeled for resident's individual use and not to be used communally.
d) Gloves are to be removed after contact with contaminated surfaces and between care of residents.
[O. Reg. 79/10, s. 229 (4)] (128) (135) (160)
2. Records were reviewed with the Assistant Administrator and there was no evidence to support that the two dogs observed visiting the home, had up-to-date immunization records. The dogs were last vaccinated July 11, 2009 and July 13, 2010.
An interview, with the Director of Activation, confirmed she was unable to verify the dogs' immunization records were current as per home's Pet Policy ACT-I-070, dated March 2011.
[O. Reg. 79/10, s. 229 (12)]
3. The Infection Control Officer/Director of Care confirmed that the Infection Prevention and Control program has not been evaluated nor updated annually in accordance with evidence based practices and/or prevailing practices. She also confirmed that a written record has not been kept including the date of an evaluation, the names of the persons who participated, a summary of the changes made, and the date those changes were implemented.
[O. Reg. 79/10, s. 229. (2) (d) and (e)]
4. Record reviews for five residents admitted to the home in 2012, revealed that none were offered immunization against pneumoccocus, tetanus and diphtheria in accordance with the immunization schedules posted on the Ministry website.
The Director of Care confirmed that residents in the home are not offered immunization against pneumoccocus, tetanus and diphtheria.
[O. Reg. 79/10, s. 229 (10) 3]
5. Record reviews, conducted with a Registered Nurse, revealed that four of the five residents reviewed(80%), who were admitted in 2012, were not screened for tuberculosis within 14 days of admission:
Two residents did not receive the first step TB testing until 16 days post admission.
One resident did not receive the first step TB testing until 25 days post admission.
One resident did not receive the first step TB testing until 35 days post admission.
The Director of Care confirmed her expectation is that residents have their tuberculosis screening tests within 14 days of admission if not given in the 90 days prior to admission.
[O. Reg. 79/10, s. 229(10) 1]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 following maintenance issues were identified in the home
It was noted that the walls in the entrance, of an identified resident room were damaged and the paint was chipped, the baseboards were scraped, the baseboard heater under the window was scraped, and the door frame at the entrance to the room was chipped. Additionally, the bathroom door was damaged and paint chipped and so were the door frames. The walls of the bathroom were scraped and the one wall was damaged with gouges in it.
Observations in a spa room revealed that the one ceiling tile in the tub area was stained with a rusty coloured substance and five ceiling tiles in the area of the toilet were water marked/stained. It was also noted that the door to the spa had black scuff marks on it and had paint chipped off it.
The cupboards in the servery area, in a dining room, are yellowed. The toaster sits below these cupboards. It was also noted that the tables and chairs in this dining room were scuffed and the finish was worn off.
The finish on table and chairs legs were scraped and in need of refinishing in two dining rooms. The baseboard heater/cooling system had paint scraped off throughout the dining room.
During an interview, the Director of Environmental Services acknowledged that the home's expectation is that it is well maintained and kept in a good state of repair.
[LTCHA, 2007 S.O. 2007, c.8, s.15 (2)(c)] (135) (190)
2. Housekeeping issues were observed in the home including:
A build up of brownish/black debris was observed around the base of the toilet in two identified resident bathrooms.
The floor in the tub area of a 'spa room' was observed to be dirty under and around the tub. The general floor area had a build up of dust and debris on it, as well. There was a build up of dirt around the door frame on the floor entering the tub area and the grouting on the tub room floor has a build up of black debris in it.
An accumulation of dust behind the fish tank, on the bubble tank and on the floor of a lounge was observed throughout the inspection. Additionally, the bubble tank had a build up of water stains on the acrylic surface. The windows of a lounge were dirty, including a build up of cob webs and were splashed with a milk-like substance. Window sills were observed to have dust, black soil from plants and leaves on them. The floor had kleenex and dust balls on it near the windows.
The servery area, in a dining room, had dirt and debris along the edges of the cupboards and steam table.
A dining room had numerous chairs seats that were stained with food and fluid-like substances. A black mould-like substance was noted on the silicone caulking of the servery sink behind the steam table and the windows in dining room looking out into corridor were spattered with a cream coloured substance. Cobwebs were noted along wall baseboards in this dining room. The small chest freezer used to store ice cream and sherbet had build up of 4-5 inches of ice on the inside of the cabinet.
An interview was conducted with the Director of Environmental Services to query expectations regarding housekeeping in the home. She acknowledged that the housekeeping concerns identified should have been addressed by the housekeeping staff and that the home, furnishings and equipment is to be kept clean and sanitary.
[LTCHA, 2007 S.O. 2007, c.8, s.15 (2) (a)] (135) (190)

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The Resident Abuse and Neglect policy, #ADM-RR-11-220, dated December 2008 was reviewed to determine compliance with the LTCHA and Regulations. The policy has not been updated since the LTCHA came into effect July 1, 2010. It does not provide for a program, that complies with the regulations, for preventing abuse and neglect nor contain an explanation of the duty under section 24 of the Act to make mandatory reports.
The Administrator acknowledged, March 1, 2012, that the policy was written in December 2008 and reviewed in March 2011.
[LTCHA, 2007 S.O. 2007, c.8, s.20(2)]

Additional Required Actions:

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

WN #8: 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. A review of the quality improvement program revealed that there is no evidence to support that the home has fully implemented a system that analyzes, evaluates and improves the quality of the accommodation, care services, programs and goods provided to residents.
During an interview with the Administrator, he acknowledged that the home's quality improvement program is still evolving and they have not fully implemented the analysis and evaluation components of the program.
[LTCHA, 2007 S.O. 2007, c.8, s.84]

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 continues to develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home, 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. An unattended, labelled bottle of medication was observed sitting at a nursing station desk.
The Director of Care acknowledged that medications should not be left unattended at any time and that this did not meet the home's expectation.
A Registered Nurse also acknowledged that he/she was aware that medications must be locked at all times.
[O. Reg. 79/10, s. 129 (1) (a) (ii)]
2. The home did not ensure that drugs stored, in a medication cart complied with manufacturer's instructions for the storage of the drugs as evidenced by:
Four bottles of medication were observed opened and not dated when opened.
One medication and one container of topical cream had expired. A Registered Practical Nurse confirmed the expiry dates of the medications as well as the expectation to record the date when medication is opened and to discard medications when they are expired.
The Director of Care and Assistant Director of Care confirmed the home's expectation for the safe storage of medications and removal of expired drugs stating registered staff are responsible to check medication labels and expiry dates of medications stored in medication carts and government stock.
[O. Reg. 79/10, s. 129 (1) (a) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all drugs are kept secure and locked and that the manufacturer's instructions for the storage of drugs are complied with, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. Two inspectors noted that the air temperature felt very cool in the area near a door. Residents congregate to sit in this area. One resident, who was sitting in the area, upon questioning, stated that it was cold and that that the home had the "cooler" on. A Registered Nurse stated that she knew that the area was cool but took no action.
The Director of Environmental Services took the temperature of the area, upon request, and the temperature fluctuated between 14 degrees and 17 degrees Celsius. She revealed that the home recognized that the door in this area opened and closed frequently so that it was cooler than the rest of the building. She revealed that she was aware that they were required to maintain the home at a minimum of 22 degrees Celsius at all times.
[O. Reg. 79/10, s.21]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all areas of the home are maintained at a minimum temperature of 22 degrees Celsius, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following subsections:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

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

Findings/Faits saillants :

1. The education records were reviewed on March 1, 2012 to determine if staff have received annual training related to abuse recognition and prevention. The records indicate that 56 staff members have not been provided annual training. The Administrator confirmed in an interview that the home has not provided annual training related to abuse recognition and prevention for all staff members.
It was also noted that all staff who did receive training were trained based on the home's Abuse and Neglect policy which is not in compliance with the LTCHA and Regulations.
[O. Reg. 79/10, s.221 (2)1]
2. Interviews were conducted with two Personal Support Workers to determine if they received any education in pain management. Both Personal Support Workers confirmed that they had not received any education nor were they aware of any specific pain management techniques other than medications. They stated they did not know how to tell whether a resident was in pain or not other than when the resident tells them, or the residents are calling out in pain.
An interview with the Director of Care confirmed that the home does not have a pain management program. She also confirmed that education regarding pain management has not been conducted with staff providing care to residents.
[O. Reg. 79/10, s.221 (1)4]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff who provide direct care to residents receive training related to pain management, including pain recognition of specific and non-specific signs of pain. Please also ensure that all staff receive annual training in all areas required under subsection 76(7) of the Act and that the training provided is in compliance with the legislation and regulations, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 10. Recreational and social activities

Specifically failed to comply with the following subsections:

s. 10. (1) Every licensee of a long-term care home shall ensure that there is an organized program of recreational and social activities for the home to meet the interests of the residents. 2007, c. 8, s. 10 (1).

Findings/Faits saillants :

1. The organized recreational and social activities program does not meet the interest of the residents as evidenced by:
Two daughters of an identified resident voiced their concerns that the recreation and social activities program currently offered by the home do not meet the resident's interests or quality of life needs related to a decline in cognitive and physical status.
An interview with an identified resident revealed that he/she will attend the activities but he/she is not interested in many activities offered at the home, and would enjoy more outings for shopping, stating the home has reduced the outings previously offered. He/she would also like to play bingo at a bingo hall.
A review of the current recreational and social activities program with the Activation Manager confirmed that the admission assessment tool currently used does not capture the needs or interests of residents who are cognitively impaired and dependent, and processes have not yet been developed and formalized to monitor the level of participation and interest of residents with activities.
[LTCHA, 2007 S.O. 2007, c.8, s. 10 (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is an organized program of recreational and social activities for the home to meet the interests of the residents, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The Resident Personal Care Items policy # IC-I-195, dated January 2012, was reviewed. The policy states personal care supplies used by residents are labelled, cleaned and disinfected. The home's Resident Personal Care Items policy was not complied with as evidenced by:
-unlabelled personal care items including combs, hair and tooth brushes, denture cups, nail clippers, a nail file, cuticle trimmers, scissors, bed pans, urinals, urine collection hats, deodorant, personal skin care, and hair products and were observed.
The Infection Control Officer/Director of Care confirmed that the Resident Personal Care Items policy # IC-I-195 was not followed related to cleaning, disinfection and labelling of nail clippers, labelling of deodorant and hair and toothbrushes for resident's exclusive use.

The Hand Washing and Hand Sanitizing policy # IC-I-100, dated March 2011, was reviewed. The policy indicates that staff should wash their hands after contact with objects that are likely to be contaminated.
During a lunch meal in a dining room staff were observed handling dirty dishes and serving resident meals without evidence of handwashing/hand hygiene inbetween.
The Infection Control Officer/Director of Care confirmed that the Hand Washing and Hand Sanitizing policy # IC-I-100 was not followed when staff were observed serving residents meals with no handwashing/hand hygiene after clearing dirty dishes.

The Procedure for Disinfecting Urinals and Bedpans policy # IC-I-170, dated July 2007, was reviewed. The policy states that urinals are to be removed and taken to the dirty utility room and sprayed with disinfectant and then are to be left to dry on the racks.
The Infection Control Officer /Director of Care confirmed that personal care items are to be stored properly and that the Procedure for Disinfecting Urinals and Bedpans policy # IC-I-170 was not followed when bed pans, urinals, urine collection hats and wash basins were left on resident washroom floors rather than being stored in clean utility rooms.
[O.Reg.79/10, s. 8 (1)(b)]
2. The Laboratory Procedures-Admission policy # NS-I-050, dated January 2011, was reviewed. The policy states, a 2-step Mantoux TB skin test immunization will be administered on admission.
The Director of Care confirmed the Laboratory Procedures-Admission policy # NS-I-050 was not reviewed or updated to meet the current legislative requirement that residents be immunized for tuberculosis within 14 days of admission unless the resident has been screened, 90 days prior to admission.
[O.Reg.79/10, s. 8(1)(a)]
3. The home has failed to ensure that a policy supporting a falls prevention and management program is in compliance with and implemented in accordance with all applicable requirements under the LTCHA.
The Director of Care and Assistant Director of Care confirmed that the current "Falls & Injuries Policy and Procedures" Policy # NS-II-260, dated January 2011, has not yet been reviewed and updated to meet the new legislative requirements for falls prevention.
[O.Reg.79/10, s. 8(1)(b)]
4. The Nutritional Care-Diet Orders policy # DTY-II-500, dated December 2011, was reviewed. The policy states: any resident observed as refusing to eat on a regular basis is referred to the Physician and to the Registered Dietitian for reassessment of nutrition status and risk.
This policy was not complied with when the Registered Dietitian was not contacted regarding a high risk resident's refusal to eat on a regular basis.
A Personal Support Worker confirmed the resident had not been eating well for two or more weeks.
An interview with the Registered Dietitian confirmed that the resident had not been referred for reassessment of nutritional status and risk until February 27, 2012.
[O.Reg.79/10, s. 8(1)(b)]
5. The Nutritional Care-Diet Orders policy # DTY-II-480, dated December 2011, was reviewed. The policy states nursing staff notifies the dietary department if at anytime a resident is not eating or is unable to consume or tolerate the prescribed diet. A resident who is unable to eat due to brief illness may be offered a diet/texture that is better tolerated. After 48 hours if the resident is still having difficulty the Registered Dietitian or Physician must be contacted for a prescribed diet order change.
The policy was not complied with when neither the Registered Dietitian nor the Physician were contacted after 48 hours of providing an identified resident a texture modified diet.
The resident was observed at lunch and was provided a texture modified entree.

A Dietary aide confirmed that the resident had not been eating well for the last month and nursing staff were trialing the resident on a texture modified diet.
The Registered Dietitian confirmed a referral related to the texture modified diet was sent February 27, 2012.
[O.Reg.79/10, s. 8(1)(b)]
6. The Weight policy # NS-II-470,dated January 2012, was reviewed. The policy states changes in residents with 2.2 kgs. more or less difference from previous month's weight will be re-weighed on their next bath day and this will be recorded on the PSW Skin Check Sheet. The weight policy was not complied with when three identified residents were not re-weighed in February 2012, and had a weight loss of 2.2 kgs or more since January 2012.
A Registered Nurse and Registered Practical Nurse stated residents weights are no longer recorded on the PSW Skin Check Sheet and are now recorded on the Point of Care system. Both confirmed after checking Point of Care that these residents had not been reweighed.
[O.Reg.79/10, s. 8(1)(b)]
7. A review of trust account policy ADM-FN-I-080 Resident's Monies and Belongings revealed that the Home's trust account is interest-bearing and the policy is not in compliance with legislative requirements.
During an interview with the Assistant Administrator it was confirmed that policy #ADM-FN-I-080 has not been updated to reflect that the home has a"non-interest bearing account" for resident funds held in trust. This policy is still being given to residents upon admission.
[O.Reg.79/10, s. 8 (1)(a)]
8. The home failed to ensure that the removal of identified expired medications and the labeling and dating of specific medications was complied with, consistent with the home's Medical Pharmacy Policy 5-1 Expiry and Dating of Medications. This was evidenced by observations of seven containers of medication labeled without prescription for unidentified residents; two medications including one topical medication that had expired and four bottles of government stock medication opened and not dated when opened.
The Director of Care confirmed the home's expectation for the removal of expired medications and appropriate labeling and dating of opened medications from government stock is consistent with their Medical Pharmacy Policy # 5-1 Expiry and Dating of Medications.
[O.Reg.79/10, s. 8 (1)(b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the licensee is required to institute a plan, policy, protocol, procedure, strategy or system this it is in compliance with and is implemented in accordance with applicable requirements under the Act; and that it is complied with, to be implemented voluntarily.

WN #14: 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. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals;
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. Three containers of medication were observed stored in a medication cart, for unidentified residents and without a written prescription. A Registered Practical Nurse confirmed that the medication was not prescribed by a physician and that it should have been discarded.
[O. Reg. 79/10, s.131(1)]
2. Two prescription creams were observed in the cupboard in a spa room.
Two Personal Support Workers were present in the spa area and upon questioning, one of them stated that they do sometimes apply prescription creams when the Registered staff tell them to. Upon further questioning the PSW acknowledged that they have not had any education related to application of the creams.
During an interview with a Registered Practical Nurse and a Registered Nurse, they both confirmed that Registered Staff are responsible for applying prescription creams for residents. They stated that this is not delegated to front-line staff and they confirmed that prescription creams should not be available in spa rooms.
[O. Reg. 79/10, s.131(4)(a)(b)and(c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. Additionally, the plan should ensure that no topical creams are applied to residents by staff members who have not been trained or are under the supervision of the registered nursing staff, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following subsections:

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

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) an explanation of the duty under section 24 to make mandatory reports;
(e) the long-term care home's procedure for initiating complaints to the licensee;
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints;
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained;
(h) the name and telephone number of the licensee;
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home;
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home;
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges;
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge;
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs;
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents;
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package;
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations;
(q) an explanation of the protections afforded by section 26; and
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. Each resident and family is not provided with a package of information upon admission.
During a resident interview it was confirmed that the resident did not know about the Residents' Bill of Rights and indicated that he/she was not provided a package of information upon admission. The resident's family accompanied them during the admission meeting with the Assistant Administrator and they were not provided with a copy of the information either.
[LTCHA, 2007 S.O. 2007, c.8, s. 78 (1) (a) and (b)]
2. The Director of Care stated during an interview that nursing does not provide written copies of the Residents' Bill of Rights, minimizing of restraint use, mandatory reporting of abuse and neglect and whistle-blowing protection.
During an interview with the Assistant Administrator it was revealed that residents are not given a package of information on admission that would include a copy of Residents' Rights, information about Residents' Council, or policies related to minimizing restraint use, mandatory reporting of abuse and neglect, and whistle-blowing protection and other requirements under section 78(2) of the LTCHA. She did indicate that she does review this information with the residents and/or families on admission but each resident and/or family are not provided with a package of information upon admission.
[LTCHA, 2007 S.O. 2007, c.8, s. 78 (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents are given an information package upon admission and that the package of information is made available to family members, as well, to be implemented voluntarily.

WN #16: 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. (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. A clinical record review revealed that an identified resident had a fall and went to the hospital.
The critical incident report was not filed within one business day.
The Director of Care confirmed that the home did not inform the Ministry within the required time frame.
[O. Reg. 79/10, s.107(3)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following subsections:

s. 52. (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.
3. Comfort care measures.
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies. O. Reg. 79/10, s. 52 (1).

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

Findings/Faits saillants :

1. An identified resident receives break-through pain medication in addition to the regularly scheduled pain medication. The medication administration record and the progress notes indicate that he/she continues to experience significant pain. No further pain assessment has been initiated to monitor the resident's ongoing pain management issues.
It was confirmed by the Director of Care that the expectation was that the pain assessment should be completed fully, including whether current interventions are adequately controlling the pain, notification of the physician of the assessment results, and signed by a registered staff member to indicate that the assessment was complete. She also confirmed that if pain is not relieved by initial interventions, the pain assessment should be continued to assess ongoing pain management.
[O.Reg. 79/10, s. 52(2)]
2. An identified resident was admitted to the home and an initial MDS assessment was not completed. The home's pain assessment was not initiated even though break-through pain medication had been administered twelve times in addition to the regularly scheduled pain medication. During the assessment period the pain ranged from 6-10, with pain medications given. The form requires a registered staff member to indicate if the current interventions are adequately controlling the pain, and if the physician was notified of the assessment result. This was not completed, nor was the assessment signed.
Another identified resident was admitted to the home and an initial MDS assessment was not completed.
No evaluation was completed of the pain information gathered during the assessment period and a physician was not notified of the assessment outcomes. The form was not signed by a registered staff member.
[O.Reg. 79/10, s. 52(1)4.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following subsections:

s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;
(c) standardized recipes and production sheets for all menus;
(d) preparation of all menu items according to the planned menu;
(e) menu substitutions that are comparable to the planned menu;
(f) communication to residents and staff of any menu substitutions; and
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The food production sheets for a lunch meal, in a dining room were reviewed and it was noted that the following menu substitutions had not been documented on the production sheets:
Minced and puree green salad with raspberry vinaigrette were substituted with coleslaw, pancakes were substituted with waffles and puree quiche was substituted with puree egg.
The Dietary Services Supervisor confirmed that the menu substitutions were not documented on the production sheets for lunch.
[O.Reg 79/10, s. 72.(2)(g)]
2. During a morning snack service the planned menu items of pineapple juice and diet peach juice were not available for residents as tropical punch and diet tropical punch were served.
During a lunch meal, in a dining room, the following planned menu items were not prepared according to the planned menu:
minced and puree broccoli quiche, minced and puree green salad with raspberry vinaigrette, and pancakes.
Additionally, the planned menu items were not available for a resident who is on a specialized diet were not available.
During an interview with the Director of Dietary services, she confirmed the above menu items were not available and it is her expectation all menu items, including specialized diets, are prepared according to the planned menu.
[O.Reg.79/10, s. 72.(2)(d)]
3. During a lunch meal service, in a dining room, the minced cucumber salad was observed to be very fine in consistency with particle size of 1/8 inch or less. The dietary aide serving in that dining room confirmed, the minced cucumber salad was not minced but more "like puree" in texture and less than 1/4 inch in particle size.
Dietary policy for Diet Menus DTY-II-480 attachment #2, was reviewed and it states that minced textured foods are either soft or easy to chew and swallow or have been ground/minced to particles of about 6 mm. or 1/4 inch.
The Director of Dietary Services confirmed that the minced cucumber salad was "over processed", not prepared using methods which preserve nutritive value or appearance and not ground to a minimum particle size of 1/4 inch as per the home's policy.
[O.Reg.79/10, s. 72. (3) (a)]

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

Specifically failed to comply with the following subsections:

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

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. Several components of the required information including the home's mission statement, policy to promote zero tolerance of abuse and neglect of residents, and the procedure for initiating complaints are kept in a binder that is located beside the first floor nursing station. This binder of information was not available on February 27, February 28 and February 29, 2012 until it was replaced by the Assistant Administrator on February 29, 2012 at 1130. The minimizing of restraining of residents policy has not been posted and was not available in the binder.
It was confirmed by the Assistant Administrator that the binder of information was not available to residents from February 27-29,2012. She also confirmed that the minimizing of restraining of residents policy has not been posted and is not available in the binder..
[LTCHA, 2007 S.O. 2007, c.8, s.79(1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, to be implemented voluntarily.

WN #20: 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. A clinical record review was completed to determine if a collaborative assessment was completed for an identified resident, post return from hospital. The resident fell and sustained a fracture in the home prior to being sent to hospital. There is no evidence to support that a post-fall assessment was completed for this resident using a clinically appropriate assessment instrument that is specifically designed for falls.
The RAI Coordinator confirmed that the expectation is that a collaborative assessment for this resident, including a post-fall assessment, should have been completed.
[O.Reg. 79/10, s. 49 (2)]
2. A review of clinical records revealed that two identified residents have each had three falls. There is no evidence to support that post-falls assessments were completed using a clinically appropriate assessment instrument that is specifically designed for falls.
The Director of Care confirmed she had knowledge of the three recent falls for both residents and further confirmed that a post-falls assessment had not been conducted or yet developed by the home for implementation.
A record review was conducted and also revealed that a post-fall assessment using a clinically appropriate assessment tool was not completed after another identified resident fell.
A Registered Nurse stated that he/she was not aware of a post-falls assessment tool.
[O.Reg. 79/10, s. 49 (2)] (135)

WN #21: 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. A Resident Council representative and a Resident Council member confirmed that the dining and snack times have not been received for review by the Residents' Council group.
The Dietary Services Supervisor confirmed that dietary services is aware of this and plan to communicate and provide the opportunity for the Residents' Council to review the dining and snack times in March 2012.
[O.Reg.79/10, s. 73. (1) 2.]

WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following subsections:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. A Residents' Council representative confirmed that he/she was unaware of the requirement and that the licensee does not respond to Residents' Council related to concerns or recommendations in writing within 10 days.
The Administrator confirmed that he was unaware of the requirement and has not responded to Residents' Council related to concerns or recommendations in writing within 10 days.
[LTCHA, 2007 S.O. 2007, c.8, s.57(2)]

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

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

Findings/Faits saillants :

1. The home has not sought the advice of the Residents' Council in developing and carrying out of a satisfaction survey, and in acting on its results.
A Residents' Council representative confirmed that he/she is not familiar with the home's satisfaction survey and that the Council has not been asked to provide input in the development of a satisfaction survey, and that the home has not shared with Council the survey results.
The Administrator confirmed that the home did not seek the Residents' Council advice in the development of the current satisfaction survey and that the results have not been shared with the Council to allow the Council to act on its results.
[LTCHA, 2007 S.O. 2007, c.8, s.85(3)](160)
2. The home has failed to document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.
A Residents' Council representative confirmed that the satisfaction survey results have not been shared with the Council and the home has not asked Council advice about the survey results.
The Administrator confirmed that the home has not shared the results of the current satisfaction survey with the Residents' Council in order to seek their advice.
[LTCHA, 2007 S.O. 2007, c.8, s.85(4)a](128)

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control

Specifically failed to comply with the following subsections:

s. 88. (2) The licensee shall ensure that immediate action is taken to deal with pests. O. Reg. 79/10, s. 88 (2).

Findings/Faits saillants :

1. A mound of ants approximately the size of a dime was observed on the floor under the grab bar and around the base of the toilet, in an identified resident bathroom, on February 23 and February 27, 2012. The ants were still present around the base of the toilet on February 28, 2012. Immediate action to deal with the pests was not taken.
The Director of Environmental services acknowledged that the expectation is that the ants would have been documented on the daily logs filled out by the housekeeping aides so that action could have been taken.
There was no evidence to support that the ants had been documented on the daily housekeeping logs. However, the housekeeping aide had expressed awareness that the ants were in the bathroom.
[O.Reg.79/10, s. 88 (2)]

WN #25: 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. Staff interviews were conducted with front-line staff to determine if they had received training in the area of whistle-blowing protections. Four Personal Support Workers and one Dietary Aide indicated that they were not aware of the meaning of whistle blowing protection.
There is no written evidence to support that education has been provided to staff in the area of whistle blowing protection.
The Assistant Administrator confirmed that the staff have not received training related to whistle blowing protection.
[LTCHA, 2007 S.O. 2007, c.8, s.76(2)5]

Issued on this 28th day of March, 2012

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

Ruth Hildebrand

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RUTH HILDEBRAND (128), BONNIE MACDONALD (135), PEGGY SKIPPER (160), SANDRA FYSH (190)
Inspection No. / No de l'inspection :	2012_087128_0005
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Date of Inspection / Date de l'inspection :	Feb 17, 19, 21, 22, 23, 24, 27, 28, 29, Mar 1, 2, 3, 5, 6, 7, 8, 12, 13, 14, 15, 16, 19, 20, 21, 22, 27, 2012
Licensee / Titulaire de permis :	SHARON FARMS & ENTERPRISES LIMITED 1340 HURON STREET, LONDON, ON, N5V-3R3
LTC Home / Foyer de SLD :	KENSINGTON VILLAGE 1340 HURON STREET, LONDON, ON, N5V-3R3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LESLIE HANCOCK

To SHARON FARMS & ENTERPRISES 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, S.O. 2007, c.8, s. 6(2).
The plan must include how plans of care will be completed on an ongoing basis based on an assessment of the residents needs and preferences.

Please submit the plan to LondonSAO.moh@ontario.ca by April 18, 2012.

Grounds / Motifs :

1. A record review revealed that the plan of care does not provide information regarding an identified resident's preferred rising or bedtime preferences.
A Personal Support Worker stated that if they require information regarding a resident's preferences, they would refer to the resident's plan of care for this information. (190)
2. A record review confirmed that the current plan of care does not reflect a comprehensive interdisciplinary assessment or identify the resident-specific preferences and interests voiced by an identified resident.
The Activation Manager confirmed there was little interdisciplinary involvement or comprehensive assessment in the development of the resident's plan of care.
A review of the resident record for an identified resident revealed that 27 days after admission, the plan of care on the computer lists 3 foci:
- risk of falls with interventions
- alteration in supervised/organized recreation with interventions
- supervision with eating with interventions
There are no identified pain issues on the plan of care, nor interventions to deal with pain control.
A Personal Support Worker was questioned about what he/she would do if a resident had pain. He/she indicated that he/she would report it to the nurse at the desk or the nurse doing medications. When asked about directions or instructions about the care of a resident, specifically about pain relief, he/she stated that it would likely be on the care plan.
The RAI Coordinator confirmed that a plan of care specifically regarding pain control and interventions has not been developed for the identified resident even though the initial pain assessment and ongoing progress notes indicate that identified resident was experiencing significant pain.
It was also noted on the dietary profile that the resident had an allergy/intolerance to peanuts and clear direction was not provided to staff and others who provide direct care. This allergy was not listed in the allergy section on Point Click Care, nor was it noted on the paper chart.
When questioned, a Registered Nurse was not aware that the resident had an allergy. (190)
3. A record review confirmed an identified resident's plan of care did not have an assessment of sleep preferences or sleep patterns, preferred time in the morning to rise nor bathing preferences.
A Personal Support Worker confirmed that this information should be on the plan of care but he/she said he/she had no idea whether it was there or not.
The RAI Coordinator confirmed to Inspector #135 that all residents sleep preferences would not be documented as she was not familiar with the LTCHA. (128)
4. Interviews with an identified resident's two daughters revealed that the current recreational and social activities offered are no longer effective in meeting the resident's needs and interests with quality of life, related to a recent decline in cognitive and physical status. Different approaches have not been considered with family input to determine options.
The Activation Manager confirmed that the activation program currently does not have a process in place to re-assess residents recreation and social needs or interests, and does not have a process for monitoring the level of participation with activities.
A review of this resident's current activation plan of care, which was last updated in 2010 indicates that it was not based on an interdisciplinary assessment of the resident's activity pattern and pursuits and that the goals that have not been re-assessed to identify the resident's current interest and needs related to a decline in cognitive and physical status.
The Activation Manager confirmed the need to re-assess the resident using an interdisciplinary assessment and establish a plan with consideration for different approaches that will more effectively provide enjoyment and improved quality of life specific to the resident's needs. (160)
5. A record review confirmed an identified resident's plan of care did not have an assessment of sleep preferences or sleep patterns.
An interview with the RAI Co-ordinator confirmed that the resident has not had an interdisciplinary assessment for sleep preferences or sleep patterns. (135)

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 25. (1) Every licensee of a long-term care home shall ensure that,
(a) the assessments necessary to develop an initial plan of care under subsection 6 (6) of the Act are completed within 14 days of the resident's admission; and
(b) the initial plan of care is developed within 21 days of the admission. O. Reg. 79/10, s. 25 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 25(1) to ensure that the assessments necessary to develop initial plans of care under subsection 6 (6) of the Act are completed, on an ongoing basis, within 14 days of the resident's admission; and that
(b) the initial plans of care are developed within 21 days of the admission of residents. The plan must also include confirmation that the identified assessments and plans of care for the 12 residents admitted in January and February 2012 have been completed.

Please submit the plan to LondonSAO.moh@ontario.ca by April 18, 2012.

Grounds / Motifs :

1. Record reviews confirmed that the initial MDS assessments for twelve residents were incomplete. None of these residents had the initial required assessment completed within 14 days of admission so that the initial plan of care could be developed within 21 days of admission.
It was confirmed during an interview with the Director of Care and the RAI Coordinator that they were both aware that these assessments had not been completed and subsequently that plans of care had not been developed for all of these newly admitted residents. However, no further action was taken. (190)
2. An identified resident did not have an initial MDS assessment, including the pain portion of the assessment completed, despite the fact that he/she receives pain medication four times daily.
There are no interventions for pain noted on the plan of care for this resident. (190)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 18, 2012

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

1. The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s.30(1) to ensure that the following interdisciplinary programs are developed and implemented in the home:
a) A falls prevention and management program to reduce the incidence of falls and the risk of injury.
b) 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.
c) A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
d) A pain management program to identify pain in residents and manage pain.
2. Each program must,
(a) provide for screening protocols; and
(b) provide for assessment and reassessment instruments.
3. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
4. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
5. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
6. The licensee shall keep a written record relating to each evaluation that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.
7. The plan must include how staff will be provided education for each of these programs including immediate education being provided to staff related to communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.

Please submit the plan to LondonSAO.moh@ontario.ca by April 18, 2012.

Grounds / Motifs :

1. A review of the quality improvement program revealed that the home was unable to demonstrate 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.
Additionally, there is no evidence to support that there are screening protocols and assessment and reassessment instruments in place for these programs.
The Administrator acknowledged during an interview, on March 1, 2012, that he could not confirm these programs were in place.
The Director of Care revealed to the inspection team that the home does not have a comprehensive program developed and implemented for Falls Prevention and Management, Skin and Wound Care, Continence Care and Bowel Management and Pain Management. (135) (160) (190) (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 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 :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance, with O. Reg. 79/10, s. 69, to ensure that re-weighs of residents are done on an ongoing basis and that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status.

Please submit the plan to LondonSAO.moh@ontario.ca by April 18, 2012.

Grounds / Motifs :

1. During a record review it was noted that an identified resident had a weight loss of 3.5 kgs. (5.4%) in one month and was not assessed using an interdisciplinary approach, nor were actions taken for the weight loss greater than 5 % in one month.
During a record review it was noted that an identified resident had a weight loss of 3.9 kgs. (6.8%) in one month and was not assessed using an interdisciplinary approach, nor were actions taken for weight loss greater than 5 % in one month.
The Registered Dietitian confirmed that both residents had not been assessed nor were actions taken for either weight loss of 5% or more in one month. [(135)
2. A record review revealed that an identified resident had a weight loss of 5.5 kgs. (8%) since November 2011 and was not assessed using an interdisciplinary approach, nor were actions taken for the weight loss greater than 7.5 % in three months.
The Registered Dietitian confirmed the resident had not been assessed nor were actions taken for the resident's weight loss of 7.5% in three months. (135)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 18, 2012

Order # / Ordre no : 005 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 229 (4), that identifies how the home will ensure that all staff participate in the infection prevention and control program including:
a) Staff wash their hands or use hand sanitizer between handling dirty dishes and serving residents their meals in the dining room.
b) Personal care items, including urinals, urine collection hats, bed pans, wash basins and nail clippers, are cleaned, disinfected and stored properly after each use.
c) Combs, hair and tooth brushes, deodorant and personal skin care products are labeled for resident's individual use and not used communally.
d) Gloves are removed after contact with contaminated surfaces and between care of residents.

Please submit the plan to LondonSAO.moh@ontario.ca by April 18, 2012.

Grounds / Motifs :

1. Infection control risks were observed in ten shared resident rooms as well as 1st and 2nd floor spa/tub rooms including:
-unlabelled personal care items including combs, hair and tooth brushes, denture cups, nail clippers, a nail file, cuticle trimmers, scissors, bed pans, urinals, urine collection hats, deodorant, personal skin care and hair products;
-improperly stored items sitting on bathroom floors or bathroom counters or backs of toilets including clean briefs, wash basins, bed pans, urinals, and urine collection hats.

Evidence of lack of hand washing/hand hygiene, as well as improper glove use, was observed as evidenced by:
During a lunch meal in a dining room, handwashing/hand hygiene was not observed between handling dirty dishes and serving residents meals, by staff.
A PSW was observed exiting from a resident's room that had infection control precautions in place. This PSW was wearing gloves and proceeded to move the lift down the hall, stop and pick up clean linen with his/her gloved hands, and did not discard the gloves prior to entering another resident room.

During an interview with the Infection Control Officer/Director of Care the following expectations were confirmed:
a) Both registered and non-registered staff must wash their hands or use hand sanitizer after handling dirty dishes before serving residents their meals in the dining room.
b) Personal care equipment, including urinals, urine collection hats, bed pans, wash basins and nail clippers are to be cleaned, disinfected and stored properly after each use.
c) Combs, hair and tooth brushes, deodorant and personal skin care products are to be labeled for resident's individual use and not to be used communally.
d) Gloves are to be removed after contact with contaminated surfaces and between care of residents.
(135) (160) (190) (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2012

Order # /
Ordre no : 006

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

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

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 must prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(b).
The plan must include how residents will be reassessed and plans of care reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary.

Please submit the plan to LondonSAO.moh@ontario.ca by April 18, 2012.

Grounds / Motifs :

1. A clinical record review was completed for an identified resident to determine if a reassessement and plan of care revision were completed after a return from hospital. The plan of care has not been updated since the resident returned from hospital.
The RAI Coordinator was questioned about the expectations regarding reassessment and care plan revision when a resident has a change of condition upon return from hospital. She confirmed that the expectation is that the Registered staff person doing the readmission would be responsible for completing the care plan revisions. (128)
2. A clinical record review revealed that an identified resident has not been reassessed and the plan of care reviewed and revised when the resident's continence care needs changed.
The Director of Care confirmed that the expectation is that registered staff conduct re-assessment of residents continence care needs when care needs change, and confirmed that a re-assessment should have been done to address the changed continence care needs. (160)
3. A clinical record review for an identified high risk resident revealed that neither a reassessment nor plan of care revision were done when the care needs changed related to ongoing weight loss and poor oral intake.
A record review confirmed the resident's average food and fluid intake was less than 25 % at meals and snacks. His/her weight loss as of February 1, 2012 was 5.4%.
A Personal Support Worker confirmed that the resident had not been eating well for two or more weeks.
A Dietary Aide serving in the a dining room indicated that the resident had not been eating well for the last month and the Registered Nursing staff had been trialing a texture modified diet but the resident continued to spit out the food. The Dietary Aide confirmed the diet list indicates the resident is to get a regular diet and regular texture.
The resident was observed receiving a texture modified diet and had an intake of less than 25 %, on March 2, 2012.
The Registered Dietitian confirmed she was not aware that the resident's care needs had changed related to poor intake and weight loss as the resident had not been referred for a change in nutritional status until February 27, 2012. (135)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board

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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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

Ontario

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 :

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

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

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

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

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

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

Issued on this 27th day of March, 2012

Signature of Inspector / Signature de l'inspecteur : Ruth Hildebrand

Name of Inspector / Nom de l'inspecteur : RUTH HILDEBRAND

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

Ontario

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

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

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

London Service Area Office
291 King Street, 4th Floor
London ON N6B 1R8

Telephone: 519-675-7680
1-800-663-3775

Facsimile: 519-675-7685

Bureau régional de services de London
291, rue King, 4iém étage
London ON N6B 1R8

Téléphone: 519-675-7680
1-800-663-3775

Télécopieur: 519-675-7685

Date(s) of inspection/Date de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Feb. 21-24, 27-29, March 1-2, 5-8, 12-16, 19-22, 27-28, 2012	2012_087128_0005	L-000220-12

Licensee/Titulaire de permis
SHARON FARMS & ENTERPRISES LIMITED
1340 HURON STREET, LONDON, ON, N5V-3R3

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

KENSINGTON VILLAGE
1340 HURON STREET, LONDON, ON, N5V-3R3

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

RUTH HILDEBRAND (128), BONNIE MACDONALD (135), PEGGY SKIPPER (160), SANDRA FYSH (190)

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ORDER #/ GENRE DE MESURE/ORDRE NO	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
NHA/7(2)	Non-compliance	May 6, 2009 Nutritional Care Referral	135
P1.23	Unmet Criterion	Dietary Inspection February 1, 2010	135
C1.17	Unmet Criterion	Nursing Complaint May 19, 2010 L10122	112
B3.49	Unmet Criterion	Nursing Complaint June 8, 2010 L10143	105
LTCHA, 2007, S.O. 2007, c.8, s.6 (1) (c)	WN and VPC	Dietary Follow-up September 30, 2010 2010_171_2729_30Sep092845	171
O. Reg. 79/10, s. 71(4)	WN and VPC	Dietary Follow-up September 30, 2010 2010_171_2729_30Sep092845	171
O. Reg. 79/10, s.73(1)(9)	WN and VPC	Dietary Follow-up September 30, 2010 2010_171_2729_30Sep092845	171

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ORDER #/ GENRE DE MESURE/ORDRE NO	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O. Reg. 79/10, s.72(4)(c)	WN	Dietary Follow-up September 30, 2010 2010_171_2729_30Sep092845	171
O. Reg. 79/10, s.71(4)	WN and VPC	Dietary Follow-up September 30, 2010 2010_171_2729_30Sep092845	171
O. Reg. 79/10, s.70(d)	WN and VPC	Dietary Follow-up September 30, 2010 2010_171_2729_30Sep092845	171
O.Reg. 79/10, s.8(1)(b)	WN and VPC	Dietary Follow-up September 30, 2010 2010_171_2729_30Sep092845	171
LTCHA, 2007, S.O. 2007, c.8, s.15(2)(c)	WN and VPC	Nursing Complaint October 4, 2010 2010_112_2729_04Oct084340 L-01194	112
O.Reg. 79/10, s.8(1)(b)	WN and VPC	Nursing Complaint October 4, 2010 2010_112_2729_04Oct084340 L-01194	112
O. Reg. 79/10, s.24(6)	WN and VPC	Nursing Complaint October 4, 2010 2010_112_2729_04Oct084340 L-01194	112
O. Reg. 79/10, s.33(1)	WN and VPC	Nursing Complaint October 4, 2010 2010_112_2729_04Oct084340 L-01194	112
O. Reg. 79/10, s.52(2)	WN and VPC	Nursing Complaint October 4, 2010 2010_112_2729_04Oct084340 L-01194	112
O. Reg. 79/10, s.53(4)(c)	WN and VPC	Nursing Complaint October 4, 2010 2010_112_2729_04Oct084340 L-01194	112
O. Reg. 79/10, s. 131(2)	WN and VPC	Nursing Complaint October 4, 2010 2010_112_2729_04Oct084340 L-01194	112
O. Reg. 79/10, s.101(1)(1)	WN and VPC	Nursing Complaint October 4, 2010 2010_187_2729_04Oct091511 L-01136	187
O. Reg. 79/10, s.50(2)(b)(iii)	WN and VPC	Nursing Complaint October 4, 2010 2010_187_2729_04Oct091511 L-01136	187

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ORDER #/ GENRE DE MESURE/ORDRE NO	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007, S.O. 2007, c.8, s.22(1)	WN	Nursing Complaint October 4, 2010 2010_187_2729_04Oct091511 L-01136	187
LTCHA, 2007, S.O. 2007, c.8, s.21	WN and VPC	Nursing Complaint October 4, 2010 2010_187_2729_04Oct091511 L-01136	187
O. Reg. 79/10, s.51(2)(b)	WN and VPC	Nursing Follow-Up October 5, 2010 2010_112_2729_05Oct085735	112 &187
LTCHA, 2007, S.O. 2007, c.8, 6(7)	WN and VPC	Nursing Follow-Up October 5, 2010 2010_112_2729_05Oct085735	112 &187
LTCHA, 2007, S.O. 2007, c.8, s.24 (1)2	WN and VPC	Nursing Critical Incidcent October 5, 2010 2010_112_2729_05Oct102500 L-01355	112
LTCHA, 2007, S.O. 2007, c.8, s.23(1)(a)(i)	WN and VPC	Nursing Critical Incidcent October 5, 2010 2010_112_2729_05Oct102500 L-01355	112
LTCHA, 2007, S.O. 2007, c.8, s.19(1)	WN and CO	Nursing Critical Incidcent October 5, 2010 2010_112_2729_05Oct102500 L-01355	112
LTCHA, 2007, S.O. 2007, c.8, s.3(1)	WN	Nursing Complaint May 4, 2011 2011_172_2729_04May093916 L- 000517	172
O. Reg. 70/10, s.8(1)(a)(b)	WN and VPC	Nursing Complaint May 4, 2011 2011_172_2729_04May093916 L- 000517	172
O. Reg. 79/10, s.48(1)2	WN and VPC	Nursing Complaint May 4, 2011 2011_172_2729_04May093916 L- 000517	172
O. Reg. 79/10, s.50(2)(b)(iv)	WN and VPC	Nursing Complaint May 4, 2011 2011_172_2729_04May093916 L- 000517	172
O. Reg. 79/10, s. 36	WN and VPC	Nursing Complaint November 7, 2011 2011_090172_0037 L-001208-11	172

O. Reg. 79/10, s. 135(2)b	WN and VPC	Nursing Critical Incident January 17, 2012 2012_090172_0003 L-001206-11 L-001351-11 L-001352-11 L-001531-11 L-001560-11	172
LTCHA, 2007,S.O. 2007, C.8,s. 19(1)	WN	Nursing Critical Incident January 17, 2012 2012_090172_0003 L-001206-11 L-001351-11 L-001352-11 L-001531-11 L-001560-11	172
LTCHA, 2007,S.O. 2007, C.8,s. 6(1)c	WN and VPC	Nursing Complaint January 17, 2012 2012_090172_0004	172
LTCHA, 2007,S.O. 2007, C.8,s. 10(2)	WN and VPC	Nursing Complaint January 17, 2012 2012_090172_0004	172
O. Reg. 79/10, s.8(1)b	WN and VPC	Dietary Complaint January 23, 2012 2012_088135_0005 L-000053-12 L-000068-12	135
O. Reg. 79/10, s. 129(1)(ii)	WN and VPC	Dietary Complaint January 23, 2012 2012_088135_0005 L-000053-12 L-000068-12	135
O. Reg. 79/10, s.229(4)	WN and VPC	Dietary Complaint January 23, 2012 2012_088135_0005 L-000053-12 L-000068-12	135

Issued on this 27th day of March, 2012

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

Ruth Hildebrand