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
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
Jul 7, 11, 12, 13, 14, 15, 18, 20, 21, 22, 25, 26, 28, 29, Aug 2, 4, 5, 8, 9, 10, 11, 12, 17, 18, 19, 27, 29, 30, 31, Sep 2, 6, 7, Oct 3, 4, 5, 6, 2011	2011_071159_0012	Resident Quality Inspection

Licensee/Titulaire

KING NURSING HOME LIMITED
49 Sterne Street, Bolton, ON, L7E-1B9

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

KING NURSING HOME
49 Sterne Street, Bolton, ON, L7E-1B9

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

ASHA SEHGAL (159), DEBORA SAVILLE (192), GILLIAN HUNTER (130), LESA WULFF (173)

NOTE: This Inspection Report has been revised to reflect a decision of the Director on a review of an Inspector's Order(s). This revised report replaces the original report issued for this Inspection.

Inspection Summary/Sommaire d'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, Director of Care, Assistant Director of Care, Resident Assessment Instrument Coordinator, Nursing Office Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, residents, family members, volunteers, Dietary Aides, Recreation Aides, Housekeeping and Laundry Aides, Environmental Supervisor, Dietary Supervisor, Activation Manager.
(Related to H-001332-11, H-001216-11, H-001449-11)

During the course of the inspection, the inspector(s) toured the home, observed meal service, care and environmental services, reviewed policy and procedure, resident health records, incident reports, minutes of meetings.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services – Maintenance
Admission Process
Continence Care and Bowel Management
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
Sufficient Staffing
Training and Orientation

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

40 WN
22 VPC
21 CO: CO # 001-021

Corrected Non-Compliance is listed in the section titled Corrected Non-Compliance.

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1:
The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights
Specifically failed to comply with the following subsections:
s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. **Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.**
2. **Every resident has the right to be protected from abuse.**
3. **Every resident has the right not to be neglected by the licensee or staff.**
4. **Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.**
5. **Every resident has the right to live in a safe and clean environment.**
6. **Every resident has the right to exercise the rights of a citizen.**
7. **Every resident has the right to be told who is responsible for and who is providing the resident's direct care.**
8. **Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.**
9. **Every resident has the right to have his or her participation in decision-making respected.**
10. **Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.**
11. **Every resident has the right to,**
    i. participate fully in the development, implementation, review and revision of his or her plan of care,
    ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
    iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
    iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of Personal health information, including his or her plan of care, in accordance with that Act.
12. **Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.**
13. **Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.**
14. **Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.**
15. **Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.**
16. **Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.**
17. **Every resident has the right to raise concerns or recommend changes in policies and services on behalf of**

himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings:

1. The home did not ensure that privacy was maintained while personal health information was discussed.
[Long-Term Care Homes Act, 2007, S.O. 2007, c. 8, s. 3(1)11 (iv).]

a) On July 20, 2011 at 1030 hours the Physiotherapist and two aides were observed discussing resident's physiotherapy programs in detail in the common area outside the nursing station. Specific residents were discussed including names, diagnosis, goals and interventions for therapy. The staff did not attempt to secure an area where this information would not be heard by others. There were approximately 10 people in the immediate area who overheard personal health information discussed. (173)

2. The licensee did not ensure that every resident is provided a safe and clean environment in relation to the following:
[Long-Term Care Homes Act, 2007, S.O. 2007, c. 8, s. 3(1)5)]
Third Floor:
a) A spray bottle of "disinfectant cleaner" was noted on July 8, 2011 in an unlocked cupboard in the third floor shower room, the shower room door was open and was accessible by residents, this floor is a secure unit with ambulatory, cognitively impaired residents.(192)
Second Floor:
a) On July 7, 2011 a bottle of "disinfectant cleaner" was noted in an unlocked cupboard under the sink in the dining room and was accessible by residents, this floor has several ambulatory, cognitively impaired residents. (130)
b) On July 7, 2011 the common fridge in the dining room was observed to contained unlabeled food items not dated and beverages not labelled or dated. There is no process used by the home to determine if the food is spoiled or contaminated. This floor has several ambulatory, cognitively impaired residents who would have full access to this area and the food contained here. (130)

3. The licensee did not ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. [Long-Term Care Homes Act, 2007, S.O. 2007, c. 8, s. 3(1)1]

a) A specified resident reported to the home that a staff member was rude and neglectful of duty by not responding to a co-resident. The home was able to verify as per witness statements, that the nurse did not communicate with the resident in a therapeutic way. Statements show that the staff member's verbal communication was of a threatening and intimidating nature to the resident. A specified resident indicated that most residents are afraid of this staff member. (173)

b) One incident of alleged neglect was reported to the home by a specified resident, stating that staff had refused to assist her as requested. The home conducted an internal investigation confirming the allegations made by the resident and the staff member was disciplined. (173)

Inspector ID #:	ASHA SEHGAL (159), DEBORA SAVILLE (192), GILLIAN HUNTER (130), LESA WULFF (173)

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 related to ensuring that residents are provided a safe and clean environment and ensuring that residents personal health information is kept confidential and to treat residents with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity , to be implemented voluntarily.***

WN #2:
The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care
Specifically failed to comply with the following subsections:

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

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

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

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

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:
Previously issued August 17, 2010 under the Long-Term Care Programs Manual as B1.6, B2.4 and O.Reg 79/10 s.26 (3)13.

The licensee did not ensure that there is a written plan of care for each resident that sets out: clear directions to staff and others who provide direct care to the resident.
[Long-Term Care Homes Act, 2007, S.O.2007, c. 8, s. 6(1)c]

a) i) The plan of care for an identified resident does not give clear directions to staff in relation to weight loss. The plan of care includes weight loss goals within a specified time frame, however, review of the progress notes documented by the Registered Dietitian states that the resident's personal weight loss goals are unsafe. No direction is provided to staff in the plan of care related to safe weight loss. (159)

ii) The plan of care for an identified resident does not set out clear directions to staff regarding the level of care requirements for dressing and hygiene/grooming needs. Activities of Daily Living (ADL) coding from the MDS (Minimum Data Set) assessment completed in 2011 changed indicating greater difficulty in performing ADL's.
Changes in the plan of care were not developed in response to these changes. The resident indicated that they do their own care. This was observed by inspectors during the course of the review. (130)

iii) An identified resident has a mental health diagnosis with responsive behaviours. The plan of care included a problem statement that identified the behaviours but did not include specific interventions for staff to prevent or manage the behaviours noted. (192)

b) i) The care plan for an identified resident indicates that the resident requires one bed rail raised while in bed and a crash mat on the floor, however, as a result of a fall in 2011, two bed rail restraints were ordered for this resident. The care plan was not updated to reflect this change. The resident was observed with one bed rail up prior to the fall in 2011 and two bed rails immediately following the fall. Staff interviewed indicated that the change in bed rail use had been communicated to them verbally. (130)

ii) The plan of care for an identified resident does not set out clear directions to staff and others who provide direct care to the resident in relation to a change in resident's diet due to a swallowing problem. The Speech and Language Pathologist completed a swallowing assessment in 2011 and recommended a special diet and total feeding assistance. The attending physician wrote the order for the diet change. The plan of care states resident requires extensive assistance during meals and feeds themself finger foods well.(159)

c) i) The plan of care for an identified resident does not set out clear direction to staff and others who provide direct care related to Continence of Bowel and Bladder. The assessment completed in MDS indicates that the resident is on a toileting routine. No details regarding the routine are documented in the plan of care. Staff were unaware of a toileting routine for the resident, stating that the resident toilets themselves, though not appropriately most times.(192)

ii) The plan of care for an identified resident indicates that the resident brushes their teeth independently with set up only. During interview with staff and documentation reviewed for two months in 2011, it was noted that the resident required total, extensive assistance. The Plan of care was not reflective of the current needs of the resident. (192)

d) i)The plan of care for an identified resident related to skin and wound care does not identify areas of concern that require treatment and include direction to staff. Areas of skin breakdown have not been included in the plan of care with interventions required. (173)

e) i) The plan of care for an identified resident related to skin and wound does not include the resident's chronic diagnosis. Considerations related to pain, infection, and treatments are not included in the plan of care. The presence of this condition is not included in the assessment of the resident. In addition, the resident has multiple open areas on the skin. The plan does not provide a description of the areas and does not provide direction to staff related to the management of pain, frequency of re-positioning or how to prevent further skin breakdown. When observed during the inspection the resident was noted to be lying in the same position with no evidence that repositioning had been completed. (173)

ii) The plan of care for an identified resident does not include interventions related to a specific high risk behaviour. The plan has no specific directions for staff related to managing the risk, or actions to take immediately to ensure the resident's safety. The plan includes interventions which are no longer current. (192)

iii) The plan of care for an identified resident called "Decline in intellectual function", includes an intervention stating that a routine should be established without providing any details for staff to follow. (192)

f) i) The plan of care for an identified resident under Mobility indicates that all physiotherapy is on hold, although during interview it was identified that the resident is currently receiving active and passive range of motion. During interview it was identified that the resident requires specific positioning to promote comfort. The resident indicated in interview that they have discomfort that interrupts their sleep. Positioning for comfort is not addressed on the plan of care.
ii) Under bowel and bladder continence the plan of care indicates that an identified resident is to be toileted before meals, after meals, at bed time and as necessary. Staff interviewed indicated that the resident had their incontinence product changed in the morning after meals and with bedtime care. The plan of care does not reflect the care the resident is receiving.

g) i) The plan of care for an identified resident related to oral care provides no directions to staff related to the frequency that care is to be provided or how it is to be provided. During interview with family it was indicated that the resident's teeth are brushed by family members, however, Personal Support Workers interviewed indicated that oral care is provided by staff. (192)
ii) An identified resident was observed sitting in a wheelchair, slightly reclined daily between July 7 and July 25, 2011. Interview with a Personal Support Worker identified that the resident sits in a chair that is reclined except during meals for safe feeding. The plan of care does not identify the type of chair the resident is to sit in, the frequency of repositioning, or that the chair should be in the upright position during meals. (192)
iii) The plan of care for an identified resident for transfers does not provide clear direction to staff to provide care. The plan indicates two staff to transfer with a Sara lift. The plan of care also indicates the resident uses a Maxilift at all times for their transfers. Staff interviewed indicate that they use a Sara lift for all transfers. (192)

2. The licensee did not 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 the resident's care needs change or care set out in the plan is no longer necessary.
[Long-Term Care Home Act , 2007, S.O. 2007, c. 8 s. 6(10)(b)]

a) i) An identified resident, who was not on a weight loss program, experienced a significant weight loss over 3 months. There was no documentation of a referral made to the Dietitian by nursing in response to this weight change, therefore the resident was not reassessed by the Registered Dietitian in relation to this change in their care need. The resident continued to lose weight and the plan of care was not revised to reflect the current status of weight loss. (159)
ii) An identified resident was assessed during an MDS quarterly review in 2011. The plan of care was not revised as a result of a documented change in the resident's care needs. The MDS assessment completed at that time indicates that the resident's behaviours had deteriorated. There were no changes to the plan of care as a result of this assessment. (192)

b) i)An identified resident was not reassessed and the plan of care was not revised as a result of multiple recurring falls. The resident sustained seven recorded falls over an eight month period, with no reassessment or new interventions related to falls and fall prevention. (130)
ii) An identified resident exhibits verbal and physical aggression daily and based on assessment has experienced a change in their mood status. The plan of care for the resident was not reviewed and revised when interventions were ineffective and their assessed needs changed. The resident had an MDS assessment completed in 2011 that indicated there had been a change in their mood status. Interventions were not initiated for the assessed change in mood status. (130)

c) An identified resident was not reassessed and the plan of care reviewed and revised related to identified changes in continence and toileting needs. The resident had contradictory information related to level of incontinence between two assessments completed in the same month. The resident was not reassessed as a result of this contradictory information to accurately reflect the continence care needs of the resident. These changes were also not captured and updated on the plan of care for continence. (192)

d) An identified resident sustained four falls since 2010. The plan of care for the resident was not reviewed and interventions were not revised when the plan was found to be ineffective in reducing the number of falls occurring. (130)

e) An identified resident sustained 10 falls over a nine month period. The plan of care related to falls was not revised nor were strategies developed when assessments completed identified risks, when the resident's outcome scales had changed, and when interventions were found to be ineffective.

3. The licensee did not ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other. [Long-Term Care Home Act,2007,S.O.2007, c.8 s.6(4)(a)]

a) Staff did not collaborate with each other in their assessments of an identified resident. Dehydration and fluid maintenance RAP (Resident Assessment Protocol) completed in 2011 by nursing stated that the resident was refusing to drink and was below their required daily fluid amount. However, the nutritional status RAP completed five days later by the Registered Dietitian stated the resident's fluid intake was above the recommended amount of 1500ml/day. These assessments are contradictory and there was no documentation to indicate that each discipline discussed their assessment with the other. (159)

b) i) Falls management was reviewed for an identified resident. There are 10 recorded falls over a 9 month period. Post falls assessments do not always contain accurate information related to the resident's fall history and information related to gait analysis was not consistent and/or complete. (130)

ii) The plan of care for two identified residents who have had multiple falls over a nine month period in 2011 is not based on an interdisciplinary assessment with respect to risk of falls.
There is no evidence to support that disciplines other than nursing were involved in the assessment and development of a plan in relation to falls prevention. (130)

iii) Post fall assessments were not always complete and did not always contain accurate information, which resulted in an inaccurate risk level, for example; the post fall risk assessment completed in 2010 indicated that one resident is at moderate risk for falls, the post fall risk assessment completed seven days later indicated the resident is at low risk for falls. The post falls risk assessment completed the next month still identified the resident is at low risk for falls despite four recorded falls in less than two months. (130)
The current Falls Prevention and Management Program does not provide evidence that departments other than nursing are involved in the assessment and review of residents in relation to falls. The revised Falls Prevention and Management Program involves other disciplines, however, this has not been fully implemented to date. (130)

c) There has been no collaboration between disciplines in the plan of care for an identified resident in relation to pain. The Observation Record completed by the Personal Support Workers indicate that the resident was in pain 24/31 days in one month in 2011 and 14/30 days the next month. Weekly assessments indicate that there is no breakthrough medication for pain despite documentation by the Personal Support Workers that the resident was experiencing pain almost daily. Physiotherapy (PT) interventions for pain management identified in the plan of care are currently on hold. There is no evidence of a current PT assessment on the medical record that addresses the resident's needs or the presence of pain. Interview with the resident indicates that their sleep is frequently interrupted by pain. Personal Support Workers frequently document on the Observation Record that there have been changes in the resident's sleep patterns. This has not been addressed during assessment by the interdisciplinary team. (192)

4. The licensee did not ensure that the staff and others involved in the different aspects of care collaborate with each other: in the development and implementation of the plan of care.
[Long-Term Care Homes Act, 2007, S.O. 2007, c. 8, s. 6 (4)(b)]

a) Staff did not collaborate with each other in the development and implementation of the plan of care for an identified resident resulting in contradicting information. Conflicting information was noted between the RAP summaries completed by different staff members. The Dehydration and Fluid maintenance RAP completed in 2011 by nursing staff stated the resident was refusing to drink and was below the minimum fluid intake level that is in the resident's plan of care. The Nutritional Status RAP completed five days later by the Registered Dietitian stated the resident's fluid intake is above the recommended amount of 1500ml/day.

5. The licensee did not ensure that when 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.
[Long-Term Care Homes Act,2007,S.O. 2007, c.8, s.6(11)(b)]
a) An identified resident was not reassessed and the plan of care revised using different approaches when the care set out in the plan of care was not effective in relation to recurring falls. The resident sustained 10 falls over a nine month period in 2011 without revisions to the plan of care for falls prevention. Different approaches were not considered during this time period. (130)

b) An identified resident was not reassessed and the plan of care revised using different approaches to care related to

verbal and physical behaviours over a five month period in 2011. The current interventions for managing the resident's behaviours have not been successful. Two altercations with injury to co-residents have occurred in a 12 month period. The resident continues to have some interventions for responsive behaviours without any reassessment and consideration of new approaches for care. Staff indicate that the behaviours
still exist, are unpredictable and remain high risk. (173)

c) The plan of care for an identified resident was not revised and different approaches considered when the care set out in the plan of care was not effective. Documentation during the previous quarter indicates that resistance to care and inappropriate behaviours have increased. Different approaches were not considered or included in the plan of care although staff indicate that current interventions have not been effective in preventing or addressing the behaviours. (192)

d) The plan of care for an identified resident was not revised and different approaches considered for oral intake when the care set out in the plan of care was not effective. During interview and documentation review it was noted that the resident has been refusing most meals and snacks. The resident has also had a significant weight loss over the last month. The resident receives a supplement several times daily. No other interventions have been added or considered. (159)

e) The MDS assessment for an identified resident completed in 2011 indicated a deterioration in continence levels. The Quarterly Continence Assessment completed four days later indicates no change in urinary or bowel continence. A review of documentation on the Observation Record completed by Personal Support Workers indicates that incontinence of bladder has been consistent daily on each shift. The frequency of incontinence of bowel has increased from 55% to 90% two months later. The plan of care for the resident has not changed over this time and does not include interventions to maintain the resident's toileting needs related to bowel and bladder incontinence in relation to these changes.

6. Previously issued August 17, 2010 with a VPC.
The care set out in the plan of care is not provided to the resident as specified in the plan of care in relation to the following: [Long-Term Care Homes Act, 2007,S.O.2007, c.8, s.6(7)]

a) Care set out in the plan of care for responsive behaviours was not provided to an identified resident. Staff left the resident unattended for an unknown period of time on a specified date in 2011. The resident was aggressive towards a co-resident during this time. The plan of care clearly states that the staff are to have another PSW relieve the staff at all times. The
plan of care states that this resident is not to be left alone.(173)

b) An identified resident has a plan of care that states that the resident participates in recreation and social activities (1:1) three times per week. Resident participation in the recreational programming was not documented on the home's participation report for three identified months in 2011. Recreational staff confirmed the information was accurate as no programming was provided to the resident.(159)

c) The plan of care for an identified resident related to oral care indicates that the resident requires one staff to complete the entire task for them. This task is to be completed twice a day and whenever required . The resident was observed on two occasions with food debris on and between their teeth. Mouth care equipment on July 21, 2011 was dry and not used to provide mouth care for the resident as indicated in the plan of care. During interview a Personal Support Worker on July 22, 2011 the PSW indicated that the resident did not receive mouthcare that morning and is frequently resistive during mouth care so staff are not always able to complete this care. (173)

d) A specific resident was identified to be at risk of harm, requiring checks every 15 minutes. The resident was observed on July 21 and 23, 2011 for periods greater than two hours on each day and was not checked by staff for periods greater than 30 minutes on multiple occasions. Interview with staff and documentation in the medical record indicates that checks were completed hourly; staff were unaware of any risk of harm to the resident. (192)
ii)An identified resident isolates themselves for long periods daily. The plan of care for the resident states that the resident will participate in 1:1 activities 3 times per week. Staff 1:1 visits or encouragement to participate in any of the daily activities did not occur at the time of the inspection. Recreational staff confirmed the 1:1 recreational programs were not delivered to resident. (159)

e)Continence care for an identified resident was not performed as per the plan of care. The resident is incontinent and has several open areas on their skin, increasing their risk for further skin breakdown. Staff, during interview, confirmed that the toileting schedule for the resident was not followed as outlined in the plan of care.
ii) The plan of care indicated that an identified resident was to receive a tub bath twice weekly. The resident received bed baths, not tub baths for several months in 2011 and the baths were not consistently given twice weekly.

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Additional Required Actions:

CO # - 001, 002, 003, 004, 015 were served on the licensee. Refer to the "Order(s) of the Inspector" form.

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

1. The licensee of the home did not ensure that any plan, policy, protocol, procedures, strategies or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act.
[O.Reg 79/10 s. 8 (1)(a)]

a) During interview with the Director of Care and Administrator, inspectors were informed that the home is transitioning to new policies and procedures provided by the consulting company working with the home. The Director of Care indicated that the new policy for Abuse and Neglect of Residents, Oral Care, and Falls had been implemented, but these policies were not available in the home areas for the staff. Staff, when interviewed were not aware of the new policies, had not received training in relation to the new policies and stated that they were still following the old policies. Policies reviewed were the policies that were available to staff and the inspectors at the time of the review. (173)

b) The licensee's policies related to Written and Verbal Complaints were not in compliance with requirements under the Act. The policy titled Written Complaints dated November 2010 did not include:
i) all written complaints concerning the care of a resident or operation of the long-term care home shall immediately be forwarded to the Director as required in the Long-Term Care Homes Act, 2007, section 22(1).
ii) the licensee is required to forward a written report documenting the response the licensee made to the complainant immediately on completing the investigation into the complaint, or at an earlier date if required by the Director as required in Ontario Regulation 79/10, section 103(1)2. (192)

c) The policy titled Verbal Complaints dated November 2010 was not in compliance with requirements under the Act. The policy titled Verbal Complaints dated November 2010 did not include the following:
i) that every complaint shall be investigated and resolved where possible, and a response provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately as required in Ontario Regulation 79/10 section 101(1)1.
ii) for those complaints that cannot be investigated and resolved within 10 business days an acknowledgment of receipt of the compliant shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow - up response shall be provided as soon as possible in the circumstances as required in Ontario Regulation 79/10 section 101(1)2.
iii) a response shall be made to the person who made the complaint, indicating what the licensee has done to resolve the complaint, or that the licensee believes the complaint to be unfounded and the reasons for the belief as required in Ontario Regulation 79/10 section 101(1)3. (192)

d) The Complaint Record maintained for the home and referred to in the Written Complaint policy was not in compliance with requirements under the Act. The Complaint Record maintained for the home and referred to in the Written Complaint policy did not include the following:
i) action taken - date, time frames, follow-up action
ii) final resolution
iii) every date on which any response was provided to the complainant and a description of the response.
iv) any response by the complainant as required in Ontario Regulation 79/10 section 101(2)(c)(d)(e)(f). (192).

e) The policy related to Minimizing of Restraints was not in compliance with requirements under the Act. The policy related to Minimizing of Restraints did not address the following:
i) alternatives to restraints as required in O.Reg 79/10 s.109(f). (130)

f) The policy related to Meal and Snack Times (# MS-40.00(b)) dated February 2010 was not in compliance with requirements under the Act. The policy stated "organized program of dietary services to respond to residents' nutritional care needs and to provide safe personally acceptable, nutritious food to residents related to criteria P1.15, P1.16, P1-17, P1.18, B3.31. This has not been updated to reflect current legislation under the Long-Term Care Homes Act 2007 and refers to the Long-Term Care Facility Programs Manual. (159)

g) Policy V11-G-10.00 called Abuse and Neglect of a Resident was not in compliance with requirements under the Act. The policy did not include the following:
i) measures and strategies to prevent abuse and neglect as required in Ontario Regulation 79/10 section 96(c). (173)

h) The home does not have policies in place in relation to the following: pneumococal, diptheria, and tetanus immunization. (130)

i) A review of the policy and procedure manual for the Recreational and Social Activities department and interview with the Director of Activation confirmed that the current policy, protocol and procedure manual has not been revised since 2006 and is not in compliance with applicable requirements under the Long-Term Care Homes Act. Plans are in place to update the manual. (159)

j) The resident care manual located at the first floor nurse's station does not contain a "Falls Prevention & Management" policy. Policy number B-5 located in the Resident Care Manual has not been updated, to meet requirements under the Long-Term Care Homes Act, as stated by the DOC. According to the DOC, the revised "Fall Prevention & Management" policy revised November 2009, is also not readily available to staff. r.8.(1)

2. The licensee of the home did not ensure that any plan, policy, protocol, procedures, strategies or system instituted or otherwise put in place was complied with.[O. Reg 79/10 s. 8 (1)(b)]

a) The licensee did not ensure that the existing policy for oral care was complied with by care staff. Policy #B35 Personal Hygiene - Oral Care-Policy and Guidelines indicates:
i) that staff are to provide residents the opportunity to perform oral care twice a day.
ii) If the resident is not able to perform this care themselves, they will be assisted by care staff.
Oral care was inspected for an identified resident on July 21, 22, 2011. The resident did not receive oral care on either day. Staff confirmed the lack of care during interview on July 23, 2011 stating that the resident was too sleepy to perform the care. The resident was observed to have food debris in their teeth on several occasions and was noted to have mouth odour on one occasion. (173)

b) The licensee did not ensure that the policy called "Promoting Continence" (Policy # VII-E-10.02) was complied with. The policy requires that registered staff will complete all documentation regarding the resident's level of bladder/bowel continence or incontinence and planned interventions in the appropriate areas of the resident's record such as progress notes, quarterly summaries and annual reviews, medication records, flow sheets and care plan.

i) The plans of care related to incontinence of bowel and bladder for an identified resident does not reflect the assessed level of continence or incontinence for the resident or the planned interventions required for the resident. Staff were not clear on the continence care needs for the resident when care should be provided.
ii) During interviews staff indicated that residents are checked and changed upon waking and after meals. One

personal support worker indicated that residents are checked, changed or toileted every 2-3 hours. Observation of a specified resident on July 28, 2011 - the resident was not checked, changed or toileted before lunch and for a period of 2 hours and 45 minutes during observation (1100 hours -1345 hours). Evening staff interviewed indicated that residents were checked, changed or toileted before supper, and at bedtime.(192)

c) The licensee did not ensure that the homes policy on the use of Mechanical Lifts/Lifting Policy #J-1 was complied with. The policy indicates:
i) that the preferred method of lifting will be conducted with the use of mechanical lifting devices, including one-person, two person and three person lifts (not transfers).
ii) Staff are not to attempt to lift any weight over 40lbs and adherence to proper body mechanics is a must.
An identified resident sustained a fall during the inspection and staff were required to pick the resident up off the floor. Two staff were observed lifting the resident from the floor to the bed. The resident's current weight is significantly higher than the 40 pounds indicated in the policy. (192)

d) The licensee did not ensure that the policy, protocol related to Pain Management was complied with. Pain and Symptom Assessment and Management Protocol Policy # VII-G-70.00 dated July 2011 requires:
i) that registered staff complete and document a pain assessment on initiation of a pain medication
ii) when there is a change in condition with pain onset
iii) distress related to behaviours or facial grimacing
iv) 24 hour Pain and Symptom Monitoring Tool is to be used when a scheduled pain medication does not relieve the pain, when pain remains regardless of interventions, pain medication is changed, or an empiric trial of analgesics is started.

a) A specified resident is on an analgesic for pain. The resident is currently experiencing pain in an additional area, as per resident interview; no assessment has been completed related to this change in condition and onset of new pain.

b) A specified resident is on analgesic related to pain. A new pain continues and the resident states that it often prohibits sleeping. No further assessment has been conducted related to this pain despite the fact that the scheduled pain medication does not relieve the pain.

c) Interview with the Director of Care indicates that the 24 hour Pain and Symptom monitoring tool is not in use in the home despite its requirement in the homes policy," Pain and Symptom Assessment and Management. (192)

e) Policy and Procedure #VII-G-10.0 called Abuse and Neglect of a resident - Actual or suspected states:
i) "all staff and volunteers will receive in-service education on the topic of abuse and neglect and the reporting of abuse and neglect."
The home has provided only one in-service education session related to abuse, neglect and whistle-blowing protection in the past year. There were only 22 staff present for this in-service education. No other attempts to repeat the education have been made to ensure that all staff have received the required training. (173)
ii) "the charge nurse will assess and evaluate injuries and document each shift for a minimum of 72 hours post incident."
The Registered Practical Nurse involved in an incident with an identified resident in 2011 did not document the incident itself or any other notes as required for 72 hours. (173)

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Additional Required Actions:

CO # - 005 and 019 were served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #4:
The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

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:
1. The food production system did not provide at a minimum the preparation of all menu items according to the planned menu on July 18, 2011 at the breakfast meal. [O.Reg. 79/10 s. 72 (2)d]

a) The planned breakfast menu, as posted was apple juice, stewed prunes, oatmeal, marble cheese, and wheat toast. Alternate choice, included banana half, assorted cold cereal, hard boiled eggs, and blueberry muffins. The alternate entree choice, boiled eggs, and pureed scrambled eggs were not prepared and served. Four (4) residents on a diabetic diets who had dislikes/intolerance to cheddar cheese were not offered and provided a protein serving for breakfast. The cook on duty interviewed confirmed that the eggs were not prepared and the residents were served only toast/muffin. (159)

b) Pureed bananas and prune juice on the planned menu for breakfast were not available and offered to residents. Staff confirmed that there was no prune juice in the home.

2. Not all food and fluids were prepared, stored and served using methods which preserves taste, nutritive value, appearance and food quality. [O.Reg. 79/10 s. 72 (3)a]

a) July 20, 2011 vegetables (broccoli) served were over cooked and mushy. On July 7, 2011 residents who chose the Salmon Sandwich and Garden Salad and required a pureed meal did not receive a meal that looked appetizing. The puree bread and salmon filling were very liquid on the plate and ran into each other. The consistency of the puree salad was also very liquid which reduces the nutrient value and increases residents' risk for choking. (192)

b) Standardized recipes at the lunch meal July 21, 2011 were not consistently followed.
On July 21, 2011 ingredients were not measured or weighed as listed on the recipes (i.e cucumber and onion salad, and pureed french fries) resulting in reduced nutritive value, taste and appearance. Recipes for cucumber salad called for 1 1/8 cup of vinegar, the cook used 2 teaspoons of vinegar. For pureed french fries, milk and fries were not measured for the number of servings required. The quality, taste and nutrient value of the food was compromised by staff not following the recipes. (159)

c) On July 14, 2011, pureed quiche served for lunch was starchy and sticky, had excessive starch content and lacked protein. (192)

d) July 14, 2011, at approximately 1325 hours plated desserts (pureed orange slices, yogurt and ice cream) were noted on the sink counter. The ice cream was melted and almost liquified. Residents were served melted ice cream. This compromises the quality and appearance of the food and increases the risk for choking for residents with swallowing difficulties. (159)

e) Residents on the third floor did not receive the same level of food quality as residents on the first and second floor. Hot foods were panned and set up on the steam cart before 1120 hours to be served to the residents on the third floor at 1230 hours. The hot food held for an extended period (over an hour) in the steam cart, not only reduces the nutritive value, taste and appearance but also compromises quality.

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Additional Required Actions:

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

WN #5: 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:

1. The licensee did not ensure that food and fluids were served at a temperature that is both safe and palatable to the residents. [O.Reg 79/10 s. 73 (1)6]

a) July 20, 2011 at the observed lunch in the third floor dining room at 12:30 pm, food temperatures were tested in the presence of Food Service Manager and a dietary aide. The temperatures recorded were as follows:
i) cold turkey sandwiches-20 degree Celsius, should have been 5 degrees Celsius.
ii) omelettes-40 degree, should have been a minimum of 60 degrees Celsius
iii)corn salad-20 degree Celsius, should have been maximum 5 degrees Celsius compromising the quality of the food, and increasing risk for food borne illness and bacterial growth.
After discussion with the Food Service Supervisor, the hot food cart was returned to the kitchen for reheating of the food. Lunch was served approximately 35 minutes later than the scheduled time of 12:30 pm. (159)

b) It is noted that the concerns about hot food not served at palatable and safe temperatures were repeatedly voiced by the residents at the Residents' Council meetings. Food temperatures tested at the observed noon meal on the third floor confirm concerns voiced by the residents at Residents' Council meetings. (159)

2. Residents were not fed using proper feeding techniques. [O.Reg. 79/10 s. 73 (1) 10]

a) An identified resident did not attend the dining room during meal service and had been noted laying on their bed. The resident was assisted to the chair beside their bed, a Personal Support Worker was standing in front of them feeding the resident heaping teaspoonfuls of food at a rapid pace, with little time to swallow between spoonfuls.(192)

b) During the observed noon meal (July 14, 2011), an identified resident was observed in a Broda chair in a poor position, sliding down, feet dangling, lying in a flat position while being fed by a personal support worker. There was no support or padding on the chair to prevent resident sliding down and the resident was not appropriately repositioned for dining. (159)

c) An identified resident was observed sitting in high wheelchair in an unsafe position while being fed, leaning forward with no neck and head support provided.

3. Residents that had large wheelchairs and Broda chairs could not be positioned at the dining table properly because the tables are at an inappropriate height to accommodate these types of chairs. [O. Reg 79/10 s. 73 (1) 11.]

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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 ensuring proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.***

CO # - 007 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #6:
The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system Specifically failed to comply with the following subsections:

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

Findings:
1. The licensee has not ensured that the home is equipped with a resident staff communication and response system that can be easily seen accessed and used by resident, staff and visitors at all times.
[O. Reg. 79/10 s. 17 (1) a]

a) July 8, 2011 - Call bell in bathroom was not accessible for an identified resident in their room. Guides on the wall hold the call bell in place but it was noted that the end of the call bell would be behind the resident's shoulder if seated on the toilet making it difficult to access. When the call bell in the bathroom was pulled by the end of the cord it would not activate. When the cord was pulled close to the wall, the cord pulled away from the access panel. (173)

b) Aug 05, 2011 at 14:00 - Call bell in an identified room was laying on the floor at the head of the bed not accessible to residents, staff and visitors. (192)

c) July 8, 2011 at 1115 - Call bell in first floor tub room is difficult to access if a staff member was working with a resident alone as it is located on the far side of the tub, near the ceiling and out of reach. (192)

d) July 12,2011 - First Floor tub room - When the call bell over the tub was tested, the cord broke off. Call bell beside the toilet in the same tub room only works when pulled side ways, using a lot of force.(192)

e) July 12, 2011 - in an identified room - when the call bell is pulled, the cord stretches and requires a great deal of effort to activate the call bell. (173)

f) July 12, 2011 in an identified room - the bathroom call bell is looped through eye hooks which make it very difficult to

activate.

g) July 8, 2011 in an identified room - the call bell is difficult to activate without force.

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Additional Required Actions:

CO # - 008 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #7:
The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings:
1. The licensee did not ensure that staff use safe transferring and positioning devices or techniques when assisting residents. [O. Reg. 79/10 s. 36]

a) During the noon meal (July 14, 2011), an identified resident was observed in a Broda chair, sliding down, feet dangling, lying in a flat position and was being fed by a personal support worker. There was no support or padding on the chair to prevent the resident from sliding down and the resident was not appropriately repositioned for dining. (159)

b) An identified resident was observed on July 14, 2011 at 1225 in the dining room, sitting in a high wheelchair in an unsafe position, leaning forward with no neck and head support provided. (159)

c) During the inspection an identified resident was observed rolling off their bed onto the floor mat. Three Personal Support Workers were observed attempting to lift the resident from the floor. The staff did not call for the registered staff member to assess the resident prior to attempting to lift the resident from the floor. No effort was made to bring a lift to the room to complete the transfer. Three unsuccessful attempts were made to transfer the resident without a lift. The registered staff member arrived at this time to complete an assessment. The plan of care indicates that the resident should be transferred using 2 staff to interlock arms with the resident and support them during transfer. The resident sometimes participates with the transfers.

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Additional Required Actions:

CO # - 009 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #8:
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. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).
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:

1. The licensee did not ensure that the falls management and prevention program must, at a minimum: provide for strategies to reduce or mitigate falls, including monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. [O. Reg. 79/10 s. 49(1)]

i) Falls management was reviewed for three identified residents. Each resident did not receive an interdisciplinary assessment to reduce or mitigate falls. Monitoring of these residents, review of the residents drug regimes, assessment and implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids did not occur and these residents continued to sustain multiple falls as a result. (130)

2. The licensee did not ensure that when a resident has fallen, the resident is assessed and 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)]

a) An identified resident did not have a post fall assessment completed in 2010, which was the fourth fall sustained over a one month period. Staff during this period did not acknowledge ongoing multiple falls for the resident or involve any other disciplines in managing and reducing falls for the resident. (130)

b) An identified resident sustained three falls in one month in 2010. A post fall assessment was not completed after the multiple falls had occurred. The resident sustained two falls the next month, however a post fall assessment was not completed for the second fall that month. The staff member, when interviewed, indicated that the second fall assessment was not completed as the falls happened within 10 minutes of each other and they did not feel that is was necessary. Staff during this period did not acknowledge ongoing multiple falls for the resident or involve any other disciplines in managing and reducing falls for the resident. (130)

c) An identified resident sustained falls at which time, no post fall assessment was conducted: once in 2010, twice within one month in 2011. During a nine month time period from 2010 to 2011 the resident sustained a total of 10 falls. Staff did not acknowledge ongoing multiple falls for the resident or involve any other disciplines in managing and reducing falls for the resident. (130)

d) An identified resident sustained falls in 2010 and 2011 at which time no post falls assessments were conducted. A clinically appropriate assessment was not used to assess the resident post fall on 7 other occasions over a one year period. Staff did not acknowledge ongoing multiple falls for the resident or involve any other disciplines in managing and reducing falls for the resident.

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Additional Required Actions:

CO # - 010 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #9:
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. (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:

1. The licensee did not ensure that when a resident's pain is not relieved by initial intervention, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [O.Reg. 79/10 s. 52(2)]

An identified resident received a medication as needed for pain. The pain was not relieved as evidenced by the resident continuously exhibiting behaviours that would indicate pain. Discussion with the Registered Practical Nurse confirms

that no pain assessment was conducted after a fall sustained by the resident. The resident was receiving pain medication on an as needed basis without further investigation into these behaviours that would suggest pain. Discussion with the Director of Care confirms that there is no clinically appropriate assessment instrument in use at the home at this time.

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Additional Required Actions:

CO # - 011 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #10:
The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours
Findings/Faits saillants :
Specifically failed to comply with the following subsections:

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

s. 53. (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(a) integrated into the care that is provided to all residents;
(b) based on the assessed needs of residents with responsive behaviours; and
(c) co-ordinated and implemented on an interdisciplinary basis. O. Reg. 79/10, s. 53 (2).

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(c) a written record is kept relating to each evaluation under clause (b) 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. 53 (3).

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

Findings:

1. The licensee has not ensured that all program and services, referred to in subsection (1) are integrated into the care that is provided to residents. [O.Reg. 79/10 s.53(2)a.]

a) An identified resident continues to exhibit daily behaviours as observed between July 7 and July 25, 2011. Behaviours exhibited are not consistently reported to registered staff. There is no documentation of behaviours on the resident record since June, 2011 although behaviours were observed daily. The MDS assessment completed in 2011 indicated

that the resident's mood status had deteriorated over the quarter in relation to behaviours, yet the narrative statement indicated that care plan goals and objectives had been reviewed and continue to be effective. Interventions related to wandering behaviours are on the plan of care yet the resident was not observed out of their bed except for meals. Interventions related to wandering are limited to involvement in recreational activities and 1:1 visits. There has been no documented involvement in recreation programs for the resident for the past several months in 2011. (192)

b) An identified resident was noted in documentation to demonstrate a number of responsive behaviours. The plan of care currently in place does not address all of the behaviours. There has been no documentation in the health record since May, 2011, related to responsive behaviours. Observation July 28, 2011 between 1100 and 1600 of the resident finds that the resident is quiet for long periods, then will attempt to get the attention of staff, occasionally calling out or waving. Staff were observed passing the resident while the resident was demonstrating the behaviours yet the staff did not acknowledge the resident. Interventions related to responsive behaviours observed have not been captured in the written plan of care.

2. The licensee shall ensure that, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible. [O.Reg.79/10 s.53.(4)(a)]

a) An identified resident was noted in their plan of care to demonstrate a number of responsive behaviours. During observation of the resident between July 7 and July 22, 2011 they were not out of their bed for more than a few minutes over the meal time. A review of progress notes indicates that there have been no documented behaviours for the past three months. Staff interviewed were able to identify that when the resident is disturbed they can be verbally aggressive but this is not reflected in the plan of care. (192)

b) An identified resident has had an intervention in place for an extended period of time due to responsive behaviours. Triggers for the resident's behaviours have not been identified or included in the plan of care, therefore strategies to reduce or mitigate the behaviours have not been developed. (173)

c) The responsive behaviour plan of care for an identified resident is not based on an interdisciplinary assessment of the resident that includes identified responsive behaviours, potential behavioural triggers, actions taken to respond to the needs of the resident and the residents response to the interventions. A review of the Resident Assessment (RAP) completed in 2011 also indicates that the resident exhibits behaviours. Documentation in the progress notes does not indicate the presence of any such behaviour since May, 2011 . The plan of care indicates that the resident resists care - it is not specific as to the types of care being resisted or when the behaviour occurs. There are no other behaviours noted in the plan of care and there have been no updates or changes to the plan of care based on reassessment or evaluation of the responsive behaviours since the decrease noted by staff in the progress notes. (192)

3. The licensee shall ensure that actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's response to interventions are documented. [O. Reg. 79/10 s.53 (4)(c)]

a) An identified resident exhibits daily behaviours as observed between July 7 to July 25, 2011. The MDS assessment completed in 2011 indicates that the resident sustained a change in mood status since the previous assessment, yet statements in the RAP assessment also indicate that interventions are effective. The Observation Record completed by Personal Support Workers indicate that through a two month period in 2011 the resident exhibited behaviours daily. Interventions within the plan of care do not address changes to the resident's mood status. There is no documentation within the progress notes or RAP that include the resident's response to interventions.

4. The licensee shall ensure that a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the person who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. [O. Reg. 79/10 s.53 (3)c)]
Interview with the Director of Care identifies that there has been a new team developed in relation to responsive behaviours. Meeting minutes could not be produced, but an "evaluation" of the program was provided. The "evaluation" of the program consisted of a statement that goals and objectives have not been identified for this program. The document provided was not an evaluation of the program.

5. The licensee did not ensure that the following were developed to meet the needs of the resident with responsive behaviour: Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive

behaviours. [O. Reg 79/10 s.53(1)2]

a) Strategies in the plan of care for dealing with a safety risk for an identified resident include only monitoring every 15 minutes. Strategies related to preventing escalation of the behaviours are not addressed. Interventions documented for specific behaviours indicate that "these behaviours are normal" for the resident. There are no strategies to prevent or minimize the resident's behaviours. Personal Support Workers interviewed were not able to identify strategies to minimize the responsive behaviours for the resident.

6. The licensee did not ensure that the following are developed to meet the needs of the resident with responsive behaviour: Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. [O. Reg 79/10 s.53(1)1]

a) An identified resident does not have written approaches to care developed to meet their needs that include screening protocols, or identification of behavioural triggers. The resident was identified in documentation to have responsive behaviours. There has been no further assessment of these behaviours to determine triggers or causative factors. Screening protocols that include behaviour mapping, determining precipitating factors or interventions added to the plan of care that have been successful in reducing the responsive behaviour, have not been completed.

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Additional Required Actions:

CO # - 012 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #11:
The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings:

1. The licensee did not ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to a resident: Hydration status and any risks related to hydration. [O. Reg. 79/10 s.26.(3)14]

a) Staff did not collaborate with each other in the assessment of an identified resident to develop the plan of care related to hydration. There is conflicting information between the RAPs summary completed by nursing and dietary staff. Dehydration and fluid maintenance RAP completed in 2011 by nursing stated that the resident was below their required fluid intake target. The resident is at risk for dehydration. The nutritional status RAP completed by the Registered Dietitian in 2011 stated the resident's fluid intake is above their recommended amount of fluids daily. There is no evidence that either discipline discussed the resident's hydration status in order to develop a plan of care that reflects the resident's current status.

2. The licensee did not ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to a resident: Health Conditions, including allergies, pain, risk of falls and other special needs. [O. Reg. 79/10 s.26.(3)10]

a) The plan of care for an identified resident does not include interdisciplinary assessment or interventions in relation to their health conditions, including pain. The resident has a history of cancer and currently has altered skin integrity. During interview the resident identified pain. Non-pharmaceutical interventions for pain relief have not been included in the plan of care. (192)

b) The plan of care for an identified resident does not include interdisciplinary assessment or interventions in relation to their health conditions, including pain. The Observation Record completed by the Personal Support Workers indicates that the resident was in pain almost daily. Weekly assessments completed by Registered Staff indicate that pain medication is effective and no breakthrough medication is required. Physiotherapy interventions for the resident related to pain management identified in the plan of care are currently on hold. A progress note in 2011 by Physiotherapy indicates that physiotherapy is to resume. There is no current physiotherapy assessment on the medical record that addresses the residents needs or the presence of pain. Interview with the resident indicates that their sleep is frequently interrupted by pain. Personal Support Workers frequently document on the Observation Record that that there have been changes in the resident's sleep pattern. This has not been addressed during assessment by the interdisciplinary team. (192)

c) The plan of care for an identified resident does not include interdisciplinary assessment or interventions in relation to falls prevention. There is no evidence that anyone other than nursing has been involved in the development of the plan of care for falls. (130)

d) The plan of care was not based on an interdisciplinary assessment when an identified resident sustained 10 falls in a 9 month period. Falls Risk scales completed by staff during this time frame indicated the risk for falls had increased but no referrals were initiated and there is no evidence that anyone other than nursing developed the plan of care for falls. (130)

e) The plan of care was not based on an interdisciplinary assessment for an identified resident related to falls. The resident sustained 4 falls in a nine month period. Falls risk scales completed by staff continue to indicate the resident was at low risk for falls and there is no supportive evidence that any other discipline was involved in developing the plan of care for falls.

3. The licensee did not ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to a resident: Continence, including bladder and bowel elimination. [O. Reg. 79/10 s.26.(3)8]

a)The plan of care for an identified resident related to continence was not based on an interdisciplinary assessment by staff. Personal Support Workers who provide direct care to the resident indicated that the resident is able to participate in

their continence management, and will direct and tell staff when they require care. There is no indication that discussion took place between registered staff and support staff to ensure that information related to their toileting plan was captured in the plan of care.

4. The licensee did not ensure that a Registered Dietitian who is a member of the staff of the home, completed a nutritional assessment for all residents on admission and whenever there was a significant change in a resident's health condition. [O. Reg. 79/10 s.26.(4)]

a) An identified resident had returned from hospital in 2011 and continued to decline in health status. New diagnoses of dysphagia and urinary tract infection were noted and two months later abnormal nutritionally relevant blood work was identified. There is no supportive documentation that the Dietitian completed a nutritional assessment in relation to the abnormal blood values, change in residents health status, new diagnosis of dysphagia, and urinary tract infection requiring antibiotics. (159)

b)The Registered Dietitian did not complete a nutritional assessment for an identified resident when there was a significant change in the resident's health status. The resident returned from hospital in 2011 with a diagnosis of dysphagia, unstageable ulcer, and refusal of meals. The documented food and fluid intake record for one month in 2011, indicates the resident's intake was less than one quarter of the meal or refusal of the meals (19/24 days refused all meals). The Registered Dietitian completed a nutritional assessment while the resident was still in hospital, which did not include an assessment of the resident's hydration status, food and fluid intake and an evaluation of the quantity of nutritional supplement ordered in relation to the resident's intake and requirement. (159)

c) An identified resident returned from the hospital in 2011 with a downgrade to the resident's diet texture. Interviewed registered nursing staff confirmed that a referral was made to the Dietitian for reassessment of the resident's nutritional status including diet change. It was confirmed by staff and the resident's health record that the resident was receiving the new diet texture as ordered. The resident has not received a diet assessment by the Dietitian as of July 26, 2011. Discrepancies were noted between the kitchen diet list and the current physician order.

5. The licensee did not ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to a resident: Nutritional status, including height, weight and any risks related to nutritional status. [O. Reg. 79/10 s.26.(3)13]

a) The plan of care for an identified resident was not based on an interdisciplinary assessment in relation to nutritional status. The resident sustained a 4 kg weight loss over a six month period. The resident's condition had deteriorated and they were not eating or drinking well. There is no evidence to support that nursing and dietary discussions took place to develop and implement a resident specific plan of care for nutrition and weight loss.

6. The licensee did not ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. [O. Reg. 79/10 s.26.(3) 5]

a) The plan of care for an identified resident indicates that the resident resists care. Documentation reviewed in their clinical health record also confirms that the resident has additional responsive behaviours. There have been no interdisciplinary assessments conducted to identify the cause of these behaviours, triggers, or variations in functioning at different times of the day. Staff have not conducted behaviour mapping, pain assessments, or any in-depth analysis of the resident's behaviours in order to develop and implement a resident specific plan of care to manage the behaviours. (192)

b) The responsive behaviour plan of care for an identified resident is not based on an interdisciplinary assessment of the resident. Documentation in the resident's clinical health record shows that the resident has multiple responsive behaviours. There is no evidence that an interdisciplinary assessment related to these behaviours has been conducted. Triggers and variations in functioning at different times of the day have not been identified. The plan of care has not been developed and implemented to manage responsive behaviours.

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Additional Required Actions:

CO # - 013 and 014 were served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #12:
The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs
Specifically failed to comply with the following subsections:

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

s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Findings:

1. The licensee did not ensure that the following interdisciplinary programs were developed and implemented in the home: A continence care and bowel management program that promotes continence and ensures that residents are clean, dry and comfortable. [O. Reg. 79/10 s. 48(1)3]

a) The continence care program that promotes continence and ensures that residents are clean and dry was not implemented for an identified resident. The resident is not routinely toileted to promote continence. Their continence status has changed from continent to totally incontinent over an eight month period without a significant change in their condition. (192)

b) The continence care program that promotes continence and ensures that residents are clean and dry was not implemented for an identified resident. The resident had been instructed to use their incontinent product instead of being toileted even though they were able to ask for assistance and aware of the need to be toileted. This was confirmed during an investigation into the incident after complaint by the resident.(192)

c) The continence care program that promotes continence and ensures that residents are clean and dry was not implemented for an identified resident. The resident was noted to have urine odour during interview and observation. (192)

d) The continence care program that promotes continence and ensures that residents are clean and dry was not implemented for an identified resident. The resident was noted to smell of urine during interview. (173)

e) During interview with Personal Support Workers it was identified that some residents require the application of a brief and a liner so that "they do not need to be changed as frequently". This information was confirmed by multiple staff.

2. The licensee did not ensure that each program, in addition to meeting the requirements set out in section 30, provide for assessment and reassessment instruments. [O. Reg. 79/10 s.48.(2)(b)]

a) The falls and post falls assessment tools to be completed in accordance with the home's current policy, is not a clinically appropriate assessment instrument. The home's revised assessment tool is currently in draft and has not been evaluated to determine its effectiveness.

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Additional Required Actions:

CO # - 021 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #13:
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).
s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).
s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings:
1. The licensee has not ensured that all staff who provide direct care to residents received training related to other areas provided for in the regulations. [Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.76(7)6]

a) The licensee has not ensured that all staff have received training related to the licensee's written procedures for handling complaints and the role of staff in dealing with complaints, before performing their responsibilities.
The orientation package used by the home does not include information related to the procedures for handling complaints. Staff interviewed were not aware of the policy related to dealing with complaints or indicated they had not received training on the policy. Three of three records provided for staff hired since July 1, 2010, did not include a record of training related to the complaints process. (192)

b) The licensee has not ensured that all staff have received training relating to the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities before performing their responsibilities.
During interview with the Assistant Director of Care it was confirmed that training related to equipment relevant to the staff member's responsibilities does not occur until the staff member is working on the home area. Staff interviewed indicated that they did not receive training on the safe and correct use of equipment before performing their responsibilities. Two of three records provided related to newly hired staff since July 1, 2010 did not include training records related to the safe and correct use of equipment. (192)

2. The licensee has not ensured that all staff who provide direct care to residents, received training relating to: mental health issues, including caring for residents with dementia; behaviour management; and palliative care.
[Long-Term Care Homes Act, 2007, S. O. 2007, c. 8, 76 (7)2, 3, 5.]

a) A review of training documentation and interview with Personal Support Workers (PSW), Recreational Aides, and Dietary Aides confirmed that no training related to mental health issues, dementia, behaviour management and palliative care were offered within the past year.

3. The licensee has not ensured that all staff have received retraining annually relating to the following: fire prevention and safety, emergency and evacuation procedures, the home's written procedures for handling complaints and the role of staff in dealing with complaints, cleaning and sanitizing of equipment relevant to the staff responsibilities.
[Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s. 76 (4)]

a) Interview with dietary, nursing and environmental staff confirmed that no recent training was received related to fire safety, evacuation, the management of complaints or cleaning of equipment. The home is unable to provide documentation of training related to these topics conducted in the past year.

4. The licensee has not ensured that any person mentioned in subsection (1) does not perform their responsibilities before receiving training in the areas mentioned below:
1. The Resident's 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 before performing their responsibilities. [Long-Term Care Homes Act, 2007, S.O. 2007, c. 8, s. 76(2)1-10.]

i) A review of records provided for two of three newly hired staff since July 1, 2010 does not include a record of any Orientation Training received. A review of the Orientation Package does not include a copy of the Resident's Bill of Rights. The Personal Support Worker Nursing Department Specific Orientation Skills Passport does not include a review of the residents Bill of Rights. Staff interviewed did not know of the Bill of Rights or indicated they had not received training on the Bill of Rights.(192)

ii) Two of three files of newly hired staff since July 1, 2010, did not include information related to training on the home's mission statement. Staff interviewed did not know what a mission statement was or indicated they had not received instruction on the mission statement. (192)
iii) A review of records provided for newly hired staff since July 1, 2010 provides no indication of training related to abuse or neglect of residents. During interview it was confirmed that some staff hired since July 1, 2010 received orientation to the home areas and perform their responsibilities without training on abuse, or before training on abuse and neglect of residents had occurred. (192)

iv) A review of the Orientation package provided does not include information related to mandatory reporting. Staff interviewed, which were hired since July 1, 2010 indicated they did not receive training related to mandatory reporting under section 24 before performing their responsibilities. Two of three records reviewed for the training provided to newly hired staff does not include records of training related to mandatory reporting. (192)

v) The Orientation package provided by the home to new employees does not include information related to whistleblowing protection, protection afforded by section 26 of the Act. Three of three records provided related to training for newly hired staff since July 1, 2010 does not include information related to whistle-blowing protection. Staff interviewed indicated that they were not aware of whistle-blowing protection. (192)

vi) The Orientation package provided by the home does not include the Minimizing of Restraints Policy. The Orientation

Skills Passport does not include information related to the Minimizing of Restraints. Two of three records provided related to newly hired staff since July 1, 2010 does not include a record of training on the minimizing of restraints. Staff interviewed indicated they had not received training related to the minimizing of restraining prior to performing their responsibilities. (192)

vii) A review of records provided for newly hired staff since July 1, 2010 does not include a record of training on fire and safety. Staff interviewed indicated that they had not received training on fire prevention and safety before performing their responsibilities. (192)

viii) The orientation package used by the home does not include information related to emergency and evacuation procedures. A review of records provided for newly hired staff since July 1, 2010 does not include a record of training on emergency and evacuation procedures. Staff interviewed indicated they had not been trained on emergency and evacuation procedures. (192)

ix) Two of three records provided for newly hired staff since July 1, 2010 does not include a record of training related to infection prevention and control. Staff interviewed indicated that they had not received training on infection prevention and control before performing their responsibilities. (192)

x) The Orientation package provided by the home does not refer to the Long-Term Care Homes Act, or the Regulations. One checklist included in the package has not been updated and still refers to "Standards", a term used in the Long Term Care Facility Programs Manual. Three of three records provided for newly hired employees since July 1, 2010 does not include information related to training on the Act, regulations, policies of the Ministry and similar documents that are relevant to the person's responsibilities before performing their responsibilities. Staff interviewed indicated they were unaware of the Long-Term Care Homes Act or had not received training related to the Legislation.

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Additional Required Actions:

CO # - 016, 017, 018 were served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #14:
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:
1. The licensee did not ensure that the home's furnishings and equipment was kept clean and sanitary.
[Long-Term Care Homes Act, 2007, S. O. 2007, c. 8, s. 15(2)(a)]

a) Black Beetles were observed under resident furnishings in an identified resident's room. There were approximately 3 to 4 live beetles that scurried back under the furniture when the inspector moved the item. (192)

b) Floors in all common areas, resident rooms, washrooms and dining areas are marked, scuffed, blackened with buildup of debris around baseboards and doorways. (130)

c) Furniture such as chairs, tables, couches, in common areas and resident rooms are marked, chipped, damaged, worn, upholstery torn, stained and unclean. Several chairs cushions were noted to be wet with an unknown source and

unusable by residents. (173)

d) Cobwebs noted in corners of an identified room on July 7, 2011. (192)

e) Heat registers in all common areas and resident rooms are dirty with built up blackened debris.(173)

f) Tub on third floor was observed to have red gritty material in the tub on July 7, 2011. (192)

g) Dining room equipment such as chairs and tables on all floors are unclean and sticky with unknown substances. (130)

h) Refrigerator in dining room on the third floor is not clean, food spills noted on July 7, 2011 initial walk through of home. (173)

i) Microwave oven in dining area on second floor has soil buildup and has rust on the inside of the oven and on the inside of the door. (130)

j)Cupboard under the sink on second floor dining area is soiled on the bottom of the cupboard and there appears to be leaking water from the pipe. (130)

2. The licensee has not ensured that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair in relation to the following:
[Long-Term Care Homes Act, 2007, S. O. 2007, c. 8, s. 15(2)c]

a) Chairs in all common areas and resident's rooms are chipped, damaged, upholstery worn/torn, stained and cannot be properly cleaned. (173)

b) Baseboards in the third floor dining room and an identified room are torn and pulled away from the wall creating a hazard for residents related to accessibility and tripping hazard. Heat registers in the third floor dining room and resident tub room are damaged with covers bent and falling apart, exposing the unit to residents. West hallway on third floor heat register is damaged, appears to be coming apart with cover hanging open, exposing the unit to residents. An identified room - wall heating register cover falling off, exposing the unit to the residents in the room. (173)

c) Walls have been damaged and not fully repaired (2 rooms identified). Resident washroom on third floor has wall damage that has not been fully repaired. (173)

d) Window curtains are missing hooks and therefore hanging off tracks. The curtains are not able to be fully closed to provide privacy or darkness. (173)

e) Electrical outlet cover on west wing of third floor is loose, there are open holes in the wall where the air conditioner has been installed with possible wiring exposed to residents.(192)

f) Toilet tank lid missing in an identified room during initial walk through on July 7, 2011. Toilet leaking in resident/public washroom on first floor during initial walk through on July 7, 2011 (130)

g) Shower chair in east shower room in third floor is worn unsteady and unsafe for resident use. (192)

h) Resident common washroom on 3rd floor - drywall has water damage in three locations, wooden panel is rough along the bottom edge. (173) The mirror is noted to be loose and a potential hazard for falling. (130)

i) Windows in main floor dining area are in poor repair with condensation in-between the two panes of glass. This impairs residents view to the outside area while dining, due to the windows appearing cloudy.

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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 related to ensuring that the homes furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

CO # - 020 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #15:
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:
1. The licensee does not ensure that 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. [Long-Term Care Homes Act 2007, S.O. 2007, c. 8, s. 85(3)(4)(a)(b)(c)].

a) Interview with the Administrator confirms that results of the satisfaction survey and actions taken as a result of the survey are not shared with the Resident's Council. Interview with residents who participate in Residents' Council meetings and a review of the minutes (November 2010 to June 2011) confirm that they have had no input into the content of the survey, have not received the results of the survey and have not been made aware of any actions taken as a result of the survey. Results of the survey are documented within the Quality Risk Management Minutes, but these are not made available for residents or families. (159)

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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 ensuring that the advice of Resident' Council is sought in the development and carrying out of the satisfaction survey and in acting on its results, ensuring that the results and actions taken as a result of the annual satisfaction survey are documented and made available to the Residents' Council, the residents and their families, to be implemented voluntarily.***

WN #16:
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:
The licensee did not ensure that resident weight changes were assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated. [O.Reg 79/10 s.69 (1)(2)]

i) An identified resident was not assessed by the Registered Dietitian after a significant unplanned weight loss over 3 months in 2011 and the care planning interventions were not revised to address the unplanned weight change.[O.Reg 79/10 s. 69 (2)] (159)

ii) A review of an identified resident's weight record indicated that the resident had a unplanned significant weight loss over one month in 2011. There was no supportive documentation that the resident was assessed by the Dietitian using an interdisciplinary approach. [O.Reg. 79/10 s. 69 (1)]

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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 ensuring that residents with weight changes as specified in O.Reg. 79/10, s. 69 are assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated, to be implemented voluntarily.***

WN #17:
The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning
Specifically failed to comply with the following subsections:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

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

Findings:
1. The licensee has not ensured that each resident is offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner and a snack in the afternoon and evening. [O. Reg. 79/10, s. 71 (3)(b)(c)].

i) July 15, 2011 - Not all residents were offered beverages in the afternoon. An identified resident was lying in bed and was not offered a beverage in the afternoon. Four identified residents were observed in the lounge and were not offered a beverage in the afternoon. (159)

ii) July 18, 2011 at 1440 hours four identified residents in the lounge, and three residents in their rooms, were not served beverages and snacks in the afternoon. Three residents in another lounge did not receive beverages and snacks. One of the identified residents was noted to have a significant weight loss in a one month period. Staff made no extra effort to ensure that this resident received nourishment secondary to this significant weight loss. (159)

iii) On July 15, 18, and 28, 2011 in the afternoon an identified resident was observed in their room lying in bed and was not offered snacks. (159)

iv) An identified resident was observed lying in bed in the afternoon, July 15, 18, 28, 2011. The resident was not offered snacks on these days. On July 28, 2011, the Personal Support Worker interviewed confirmed that the resident was not offered pureed snack, as there was not a sufficient supply of pureed snacks on the cart.

2. The licensee did not ensure that the planned menu items were available and offered at each meal. [O. Reg. 79/10 s.

71(4)]

i) An identified resident had consumed approximately 75% of their meal, however, had not been offered or served a beverage. The resident was not offered a beverage until the inspector spoke with the resident and asked the staff to provide a beverage. [O. Reg. 79/10 s. 71(4)]

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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 ensure that the resident is offered a minimum of a between meal beverage in the morning and afternoon and a beverage in the evening after dinner and a snack in the afternoon and evening, to be implemented voluntarily.*

WN #18:
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).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

1. The licensee has not ensured that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. [O. Reg. 79/10 s.30(2)]

a) Post falls assessments and care plan revisions for an identified resident, where necessary, were not consistently completed on three occasions over a nine month period. (130)

b) An identified resident's participation in recreational and social activities program was not documented in the home's monthly participation report for a six month period in 2011. The plan of care for the identified resident stated the resident participates in group activities passively, lack of attendance. Staff interviewed confirmed the resident participation and attendance in recreational programming had not been recorded. Interventions to deal with the lack of attendance in recreational and social programs were not documented. (159)

c) There is no documentation of an identified resident's participation in 1:1 activity program for a six month period in 2011. The plan of care for the resident states that the resident will participate in 1:1 activities three times per week. (159)

d) An identified resident was assessed to have a change in mood status and responsive behaviours. No interventions were documented related to this change. Current interventions are recorded as having been reviewed and effective although there were changes in the resident's status. Documentation within the progress notes indicates that interventions tried were not effective. (192)

e) Post fall assessments for an identified resident were not documented for falls that occurred in 2010 and 2011. (130)

f) An identified resident's participation in recreational and social activities program was not documented in the home's monthly participation report over a two month period in 2011. The plan of care for the resident stated the resident will participate in 1:1 recreational activities three times per week. Interviewed staff confirm that the resident's response to participation and attendance in recreational programming had not been recorded. (159)

g) Based on the 2011 MDS assessment, there is evidence that an identified resident demonstrates responsive behaviours. In addition, the RAP includes additional behaviours not specified in the MDS assessment. Interview with the resident on multiple occasions between July 7 and July 25, 2011 provides evidence to support that the resident is experiencing behaviours. A review of the progress notes shows no evidence of documentation related to behaviours since June 2011. Interventions that may be effective in dealing with these behaviours are not documented.(192)

2. The licensee did not ensure that the following was complied with in respect of each of the organized programs required under section 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: A written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, names of persons who participated in the evaluation, a summary of the changes made and the date those changes were implemented. [O. Reg. 79/10 s. 30 (1) 4.]

a) Documentation provided by the Director of Care related to the evaluation of established required programs (Responsive Behaviours, Skin and Wound Care, Pain Management, Fall Prevention, and Continence Care and Bowel Management),does not include the date of the review, the names of persons who participated or the date that the changes were implemented for all of the programs reviewed.

3. The licensee did not ensure that the following was complied with in respect of each of the organized programs required under section 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: There must be a written description of the program that includes goals and objectives, and relevant policies, procedures and protocols and provides methods to reduce risk and monitor outcomes, including protocols for the referral of a resident to specialized resources where required. [O. Reg. 79/10 s.30(1)1]

a) During interview with the Administrator and Director of Care it was confirmed that a written description of the program that includes goals and objectives, relevant policies, procedures, protocols, provision of methods to reduce risk, methods to monitor outcomes and protocols for referrals of resident to specialized resources where required are not available for the Restorative Care Program, Medical Services, Religious and Spiritual Practices and Volunteer Programs.

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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 ensuring there are written descriptions as per O.Reg. 79/10 s. 30(1) for all programs required under sections 8-16 of the Act and each of the interdisciplinary programs required under section 48 of the Regulation, and a written record relating to each program evaluation includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes and the date that those changes were implemented and that any actions taken with respect to a resident is , to be implemented voluntarily.*

WN #19:
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. (1) A Residents' Council of a long-term care home has the power to do any or all of the following:
1. Advise residents respecting their rights and obligations under this Act.
2. Advise residents respecting the rights and obligations of the licensee under this Act and under any agreement relating to the home.
3. Attempt to resolve disputes between the licensee and residents.
4. Sponsor and plan activities for residents.
5. Collaborate with community groups and volunteers concerning activities for residents.
6. Advise the licensee of any concerns or recommendations the Council has about the operation of the home.
7. Provide advice and recommendations to the licensee regarding what the residents would like to see done to improve care or the quality of life in the home.
8. Report to the Director any concerns and recommendations that in the Council's opinion ought to be brought to the Director's attention.
9. Review,
i. inspection reports and summaries received under section 149,
ii. the detailed allocation, by the licensee, of funding under this Act and the Local Health System Integration Act, 2006 and amounts paid by residents,
iii. the financial statements relating to the home filed with the Director under the regulations or provided to a local health integration network, and
iv. the operation of the home.
10. Exercise any other powers provided for in the regulations. 2007, c. 8, s. 57 (1), 195 (4,5).

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:

1. The licensee did not ensure that if Resident's 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 Resident's Council in writing. [Long-Term Care Homes Act, 2007, S.O. 2007, c. 8, s. 57 (2)]

a) November 22, 2010 Resident Council meeting concerns related to meals cold especially at dinner, toast cold, missing clothes, residents rooms cold, and residents want to have more Bingo were not responded to in writing by the Administrator within 10 days. (159)

b) February 2011 Resident Council meeting concerns related to lack of options for other religious practices, salty food, tea and coffee served cold, pudding/custard served lumpy and hard, residents placed at dining room table too long before meal service were not responded to in writing within 10 days by the Administrator. (159)

c) May 30,2011 Resident Council meeting concerns related to options for diabetic desserts and meat too tough were not responded to in writing within 10 days by the Administrator.

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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 ensure that within 10 days of receiving advice from the Resident's Council, the licensee will respond to the Resident's Council in writing, to be implemented voluntarily.*

WN #20:
The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping
Specifically failed to comply with the following subsections:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces;
(c) removal and safe disposal of dry and wet garbage; and
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings:
1. The licensee did not ensure that the organized program of housekeeping was developed and implemented in relation to addressing incidents of lingering offensive odours. [O.Reg 79/10 s. 87(2)d]

i) Lingering offensive odours were noted on all floors, in common areas, residents rooms and washrooms. Resident's wheelchair washroom in the hall on third floor was also noted to have significant odours. (173)

ii) During interview with the Environmental Supervisor on July 18, 2011, they noted that during the summer months the air exchange is turned off during the day to stop recirculation of humid air into the home. During this time the air exchange rate is decreased and odours are more noticeable. Staff are instructed to use a product called "Breakdown" on surfaces to reduce the odours, but no other investigation of the cause of the odours or interventions have been put in place to address odours. (173)

iii) July 7, 2011 at 1105, urine odours were noted in the second floor hallway, common washroom and in the third floor common washroom, labelled "wheelchair washroom"

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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 ensuring that procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.*

WN #21:
The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services
Specifically failed to comply with the following subsections:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at

least every six months by a certified individual, and that documentation is kept of the inspection;
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;
(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings:

1. The licensee did not ensure that procedures were developed and implemented to ensure that all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks. [O.Reg 79/10 s. 90(2)d]

i)It is noted that:
The toilet in an identified room is missing the toilet tank lid. (173)
The toilet is leaking in an identified room. (130)
The toilet tank lid in shower room on 3rd floor does not fit.

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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 related to ensuring that all identified deficiencies with plumbing fixtures, toilets, sinks, grab bars and washroom fixtures are repaired immediately and a plan is developed to ensure all items are maintained., to be implemented voluntarily.*

WN #22:
The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings:
1. The licensee did not ensure that the written policy under section 20 of the Act to promote Zero tolerance of Abuse and Neglect contains the following:
[O.Reg 79/10 s. 96 (c)(e)i,ii]

a) The licensee policy and procedure (#V11-G-10.00) called Abuse and Neglect of a Resident - Actual or Suspected does not include any measures or strategies to prevent abuse and neglect. [O.Reg 79/10 s. 96 (c)] (173)

b) The licensee's policy to promote zero tolerance of abuse and neglect (#V11-G-10.00) does not identify the training and retraining requirements for all staff, including training on the relationship between power balances between staff and residents and the potential of abuse and neglect by those in a position of trust, power and responsibility for resident care. [O.Reg 79/10 s. 96 (e)i] (173)

c) The licensee's policy to promote zero tolerance of abuse and neglect (#V11-G-10.00) does not identify situations that may lead to abuse and neglect and how to avoid such situations. [O.Reg 79/10 s. 96 (e)ii]

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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 ensuring that the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, includes measures and strategies to prevent abuse and neglect and training and retraining requirements including training on the relationship between power imbalances between staff and residents and the potential of abuse and neglect by those in a position of trust, power and responsibility for resident care, to be implemented voluntarily.***

WN #23:
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:
1. The licensee did not ensure that medications were stored in an area or medication cart that is secure and locked. [O. Reg 79/10 s.129(1)(a) ii]
Drugs stored in the medication cart on third floor during medication observation on July 18, 2011 were noted to be left in the cart unlocked and unattended twice during the medication pass. Each time the nurse left the cart outside a residents room for a period in excess of 5 minutes without locking the cart.

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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 ensuring that drugs are stored in a medication cart that is secure and locked, to be implemented voluntarily.***

WN #24:
The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following subsections:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings:
1. The licensee did not ensure that each resident of the home was bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. [O. Reg. 79/10 s. 33(1)]

a) The plan of care for an identified resident indicates that they require a two person transfer for tub bath, bath days are twice weekly and that their preference is an evening tub bath. A review of the documentation for May and July 2011 indicates that the resident has not received care as outlined on the plan of care and is receiving a bed bath less than twice weekly. This was confirmed with staff who provide direct care to the resident. (192)

b)Records indicate that an identified resident was not bathed twice weekly between July 6-13, 2011 and between July 13 and 27, 2011.(192)

c) Records indicate that an identified resident was not bathed twice weekly between July 4 - 14, 2011, July 18 and 25, 2011.(192)

d) Records indicate that an identified resident was not bathed twice weekly between July 8 - 15, 2011. (192)

e) Records indicated that an identified resident was not bathed twice weekly between July 11 and 21, 2011.

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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 related to ensuring that all residents are bathed, at a minimum, twice a week by the method of his or her choice or more frequently as determined by the resident's hygiene, to be implemented voluntarily.***

WN #25:
The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following subsections:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures;
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings:
Previously issued August 17, 2011 as a WN

1. The licensee did not ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that included: mouth care in the morning and the evening, including the cleaning of dentures. [O. Reg. 79/10 s. 34(1)a]

a) An identified resident does not receive oral care to maintain the integrity of the oral tissue as per the following: The resident had been observed on two occasions with food debris on and between teeth. Mouth care equipment for the resident was observed to be dry and not used on July 21, 2011, indicating that mouth care had not been completed. July 22, 2011 at 12:15pm - the resident was observed in the lounge area. Breath of resident was noted to be slightly odorous. Teeth appeared to be blackened and not clean. No debris noted at this time. Personal Support Worker stated that they had not given mouth care during morning care as the resident was not fully awake when they were completing personal care. (173)

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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 ensuring that each resident of the home receives oral care to maintain the integrity of the oral tissue by providing mouth care in the morning and evening, including the cleaning of dentures, to be implemented voluntarily.***

WN #26:
The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care
Specifically failed to comply with the following subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings:
Previously issued August 2010 under B1.17 (weekly assessment)
1. The licensee did not ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds: was assessed by a Registered Dietitian who is a member of the staff of the home, and any changes made to the residents plan of care relating to nutrition and hydration were implemented.[O.Reg. 79/10 s. 50(2)(b)(iii)]

a) An identified resident went to hospital with an unstageable skin wound. The dietary assessment was completed during the resident's absence from the home and did not include consideration of altered skin integrity. (159)

b) A referral was sent to the Dietitian in 2011 for an identified resident due to chewing and swallowing difficulties. No reference was made to the resident's altered skin. The Dietitian assessed the resident after receiving the referral. The Dietitian did not physically observe the resident. The texture of the resident's diet was changed without a complete

assessment. The Dietitian indicated a review of the clinical record with no reference to open areas on the resident's skin. (173)

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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 ensuring that a resident exhibiting altered skin integrity , including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented., to be implemented voluntarily.*

WN #27:
The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management Specifically failed to comply with the following subsections:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;
(e) continence care products are not used as an alternative to providing assistance to a person to toilet;
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings:
1. The licensee did not ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented. [O. Reg. 79/10 s. 51. (2)(b)]

a) An identified resident does not have an individualized plan of care to promote and manage bowel and bladder continence based on the assessment.

i) The resident was assessed as continent of bowel and bladder in 2010 and used a liner for protection between voidings. The resident's most recent assessment in 2011 indicates that the resident had become incontinent of bladder and occasionally incontinent of bowel without a significant change in their condition during the eight months between assessments. This is directly contradictory of other documentation found in the health record that includes documentation on the Observation Record which indicates that the resident is incontinent of urine daily on all shifts even though the resident is aware of the urge to void. The Observation Record related to incontinence of bowels indicates that

the resident is now incontinent of bowel 90% of the time from only 55% of the time, despite the fact that the resident is still aware of the urge to defecate. The plan of care indicates that although the resident knows when they have to go to the bathroom and can ask, they often do not. The resident is on a diuretic each morning that affects the frequency of voiding. Staff were not observed toileting the resident between 1100 and 1345 on July 28, 2011 and when interviewed staff indicated that the resident is toileted in the morning and not again until after lunch. During interview staff were not able to verbalize an effective toileting schedule for the resident and/or indicate that the resident is incontinent with behaviours related to toileting. There are no specific interventions on the plan of care that would promote continence for the resident. (192)

2. The licensee did not ensure that residents who required continence care products had sufficient changes to remain clean, dry and comfortable. [O. Reg. 79/10 s. 51(2)(g)]

i) During interview with Personal Support Workers it was identified that some residents require the application of a brief and a liner so that "they do not need to be changed as frequently". This practice while not supported by management, was confirmed by multiple Personal Support Workers. The home has received a confirmed complaint from a resident told to void in their brief after asking to be assisted to the bathroom.

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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 ensuring that each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; and that residents who require continence care products have sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.***

WN #28:
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).

Findings:

1. The licensee has not ensured that all staff who provide direct care to residents receive training relating to:
   1. fall 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. [O.Reg. 79/10, s. 221(1) 1,2,3,4]

a) A review of the homes' training records did not include training related to fall prevention and management, skin and wound care, continence care and bowel management and pain management including recognition of specific and non-specific signs of pain. (192)

b) A review of training records provided indicates that only three staff who provide direct care to residents have attended external training related to Palliative Care and Pain Management. Interview with the Director of Care confirms that staff within the home have not received training on Palliative Care/Pain Management Program. (192)

c) Personal Support Workers interviewed indicated they had not received training on falls prevention, restraints/PASD's (Personal Assistive Service Devices), skin and wound care, continence/bowel management and pain management. Training on the use of a variety of incontinence products had been conducted, but maintaining continence and bowel management was not included. (192)

d) During interview it was reported by some Personal Support Workers that, in their opinion, skin and wound care and pain management were the sole responsibility of registered staff. A Personal Support Worker interviewed indicated that she has not received training on pain management and recognition of signs of pain while employed at the home.

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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 ensuring that training is provided to all staff who provide direct care to residents related to fall prevention and management, skin and wound care, continence care and bowel management and pain management including pain recognition of specific and non-specific signs of pain, to be implemented voluntarily.***

WN #29:
The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement

Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings:
1. The licensee did not ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements: There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review. [O. Reg. 79/10, s. 228(1)]
a) During interview with the Administrator it was confirmed that the home's quality improvement and utilization review system does not have written goals and objectives, policies and procedures and a process to identify initiatives for review. (192)

2. The licensee did not ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements: A record must be maintained by the licensee setting out the communications under paragraph 3.[o.Reg 79/10 s.228(4)iii]

a) The home has no record of the communication made to Residents Council and the staff of the home regarding the improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents.

Interview with the Administrator confirmed that a record of communication is not kept as required.

3. The licensee did not ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements: The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents Council and the staff of the home on an ongoing basis. [O.Reg. 79/10 s.228 (3)]

a) During interview with the Administrator it was confirmed that the results of quality improvement initiatives are not shared with the Resident's Council. A review of the minutes of the Resident's Council from March 2011 to June 2011 confirms that they have not received information related to quality improvements that have been conducted in the home. Staff of the home interviewed related to quality improvement were unaware of goals and objectives established by the Quality Improvement Committee, they acknowledged that changes were occurring, but were unable to express any goals for their respective departments.

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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 ensuring that the quality improvement and utilization review system required under section 84 of the Act complies with subsections 1, 3, and 4 (iii), to be implemented voluntarily.*

WN #30:
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:
1. The licensee did not ensure the Director was informed of an injury of which a person was taken to hospital, no later than one business day after the occurrence of the incident, followed by the report required under subsection (4) in relation to the following:
[O.Reg. 79/10, s.107(3)(4)]
i) In 2010, an identified resident sustained two falls, which resulted in a transfer to hospital with an injury. (130)

ii) In 2010, an identified resident was transferred to hospital, with an injury. (130)

The Director of Care, acknowledged that Critical Incident Reports were not completed for either incident.

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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 ensuring that the Director is informed of an injury of which a person is taken to hospital, no later than one business day after the occurrence of the incident, followed by the report required under subsection (4), to be implemented voluntarily.***

WN #31:
The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings:
1. The licensee did not ensure that all areas where drugs are stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.[O. Reg 79/10 s.130(2)i, ii]

a) On July 15, 2011 at 1145, the Maintenance Supervisor who is unable to dispense, prescribe or administer drugs, unlocked the Government Drug Stock Room door, located in the basement, at the request of the Inspector. This room contained a stock supply of drugs.

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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 related to ensuring that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home and the Administrator, to be implemented voluntarily.***

WN #32:
The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program
Specifically failed to comply with the following subsections:

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

Findings:
1. The licensee did not ensure that immunization and screening measures were in place for residents to be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. [O.Reg 79/10 s.229.(10)3]

a) Interview with the Director of Care confirmed that a program for offering resident immunizations against pneumoccocus, tetanus, diptheria is not currently in effect. Documentation reviewed also shows that this program is not offered to residents.

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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 by ensuring that the infection prevention and control program complies with offering residents immunization against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules., to be implemented voluntarily.*

WN #33:
The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings:
1. The licensee has not ensured that every resident bedroom occupied by more that one resident has sufficient privacy curtains to provide privacy. [O.Reg 79/10 s.13]

a) The privacy curtains in two specified rooms are approximately 2 feet short. When the curtain is closed, the residents would be exposed to their room mate during personal care. (173)

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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 related to ensuring that every resident bedroom has sufficient privacy curtains to provide privacy., to be implemented voluntarily.*

WN #34:
The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain Restraining
Specifically failed to comply with the following subsections:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff.
2. Restrained, in any way, as a disciplinary measure.
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36.
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings:
1. The licensee did not ensure that any resident of the home is not restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. [Long-Term Care Homes Act, 2007 S.O. 2007, c.8, s.30(1)3]

a) The need for a restraint by a physical device is not included in the plan of care for an identified resident. In 2011 the resident sustained a fall from their bed, which led to a physician's order for 2 bed rails to be raised while in bed. The plan of care was reviewed on July 28, 2011 at 1200hrs and still directs staff to raise 1 bed rail when the resident is in bed. (130)

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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 ensuring that no resident of the home is restrained with a physical device, other than in accordance with section 31 or under common law duty as described in section 36, to be implemented voluntarily.***

WN #35:
The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.

Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices;
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device;
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others;
(d) types of physical devices permitted to be used;
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented;
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings:
1. The licensee did not ensure that the policy under section 29 of the Act deals with: alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach. [O. Reg 79/10 s.109(f)]

The home's current policy, "Restraints: Guidelines for Use, Manual #3, Policy Number B-9, dated April 2008, does not identify alternatives to the use of restraints, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach. (130)

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WN #36: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care
Specifically failed to comply with the following subsections:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings:

1. The licensee did not ensure that each resident of the home received fingernail care, including the cutting of fingernails. [O. Reg. 79/10 s. 35(2)]

a)The plan of care for an identified resident indicates the resident should have their nails checked and cleaned as necessary. During observation on July 8 and July 25, 2011 it was noted that there is thick black dirt under the resident's finger nails

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WN #37:
The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings:

1. The licensee did not ensure that each resident of the home received individualized personal care, including hygiene care and grooming on a daily basis. [O.Reg. 79/10, s.32]

a) An identified resident is dependent on staff for all aspects of hygiene and grooming. The observation record completed by Personal Support Workers indicates that personal hygiene is completed daily for the resident. On July 8 & 25, 2011, the resident was noted to have oily skin, to be partially unshaven and have dishevelled hair.

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WN #38:
The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings:

1. The licensee has not ensured that drugs obtained for use in the home, were obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. [O. Reg. 79/10 s.124]

i) The home maintains more than a three month supply of lactulose. During interview and confirmation with the Registered Practical Nurse it was identified that medications are kept on the home area and that the current supply of lactulose on the home area is more than is required by the residents. Observation of the medication storage area found that there are 19 containers of lactulose in the lower left hand cupboard in the third floor medication room.

ii) The home has a government stock drug supply that will last for a period greater than three months. The stock room in the basement was noted to have the following: 41 (500ml) bottles of milk of magnesia, 10 bottles (100 tabs) of daily vitamin supplements, 20 (100 tabs) bottles of 325mg ASA, 17 bottles (100tabs) of 600mg Slow K. This was confirmed during interview with the Director of Care.

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WN #39:
The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program Specifically failed to comply with the following subsections:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program;
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends;
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests;
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities;
(e) the provision of information to residents about community activities that may be of interest to them; and
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings:
1. The licensee did not provide assistance and support to permit an identified resident to participate in activities that may be of interest to them as they were not able to do so independently. [O. Reg. 79/10 s. 65 (2) f].

a) An identified resident's plan of care indicates the resident participates passively and smiles during group recreational programs. July 12, 15, 18 and July 22, 2011 resident was observed lying in bed and not provided assistance and encouragement to participate in the group recreational programs offered at the time of this inspection. The programs that the resident was not provided support to attend included ball toss and a snoozelan therapy program. Both programs would have been beneficial for the resident to attend, even passively. (159)

b) An identified resident disclosed that they used to participate in all home activities, however, after a hospitalization in 2011 the resident is unable to propel themselves in their wheelchair and they do not receive assistance from staff to attend the programs offered in the home.

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WN #40:
The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council
Specifically failed to comply with the following subsections:
s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings:
1. The licensee did not advise on an ongoing basis, to resident's families and persons of importance to residents, the right to establish a Family Council. [Long-Term Care Homes Act, 2007, S. O. 2007, c. 8, s. 59(7)a]

a) Interview with the Licensee/Administrator confirmed that advice to residents' families and persons of importance to residents for their right to establish a Family Council has not been provided on an ongoing basis since July 1, 2010. (159)
2. The licensee did not convene semi-annual meetings to advise such persons of the right to establish a Family Council. [Long-Term Care Homes Act, 2007, S. O. 2007, c. 8, s. 59(7)b]

a) There was no record available of the semi annual meetings convened by the Administrator/Licensee to advise

residents' families and persons of importance to residents of their rights to establish a Family Council. Interview with the Administrator/Licensee confirmed that there has had not been semi-annual meetings held to advise residents' families and persons of importance to residents of their rights to establish a Family Council.

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CORRECTED NON-COMPLIANCE
Non-respects à Corrigé

REQUIREMENT EXIGENCE	TYPE OF ACTION/ORDER	ACTION/ ORDER #	INSPECTION REPORT #	INSPECTOR ID #
O. Reg. 79/10, s.72(6)(a)	CO	002	2010-141-90116-aug164800	# 141

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Initial for A Sehgal. Dec 9-2011
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).