Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 3, 5, 7, 8, 9, 10, 14, 15, 16, 17, 18, 21, 22, 23, 28, 29, Dec 2, 2011	2011_067171_0028	Resident Quality Inspection

Licensee/Titulaire de permis

DEVONSHIRE ERIN MILLS INC.
195 DUFFERIN AVENUE, SUITE 800, LONDON, ON, N6A-1K7

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

LANARK HEIGHTS LONG TERM CARE CENTRE
46 LANARK CRESCENT, KITCHENER, ON, N2N-2Z8

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

ELISA WILSON (171), BONNIE MACDONALD (135), CAROLE ALEXANDER (112), DIANNE WILBEE (170), JUNE OSBORN (105)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, 2 Assistant Directors of Care, Managers of Food Services, Recreation Services, Environmental Services, RAI-MDS, Regional Manager of Long-term Care and Regional Manager of Quality and Education, Social Worker, Registered Dietitian, Restorative Care Coordinator, Business Manager, Staffing Clerk, Receptionist, Food Services Supervisor, Maintenance Worker, Physiotherapist and Physiotherapy Assistant, 7 Dietary Aides, 4 Housekeeping Aides, 3 Recreation Aides, Laundry Aide, 2 Registered Nurses, 17 Registered Practical Nurses, 36 Personal Support Workers, 48 residents and 5 residents' family members.

During the course of the inspection, the inspector(s) toured the home, observed meal service, medication passes, medication storage areas and care provided to residents, reviewed resident records and plans of care for identified residents, reviewed policies and procedures of the home, and observed the general maintenance, cleaning and condition of the home.

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

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee did not ensure that the following policies and procedures were complied with.

The policy and procedure Documentation & Record Keeping System (ESM04-01-03 updated September 2011) indicated the home was to establish an organized, complete and consistent system of documentation and record-keeping related to routine, preventative and remedial maintenance and the home was to provide readily-accessible evidence that systems and equipment have been routinely monitored and actions taken where needed. The policy included a form entitled Master Schedule - Preventative Maintenance.

The home was unable to produce completed preventative maintenance forms or readily-accessible evidence indicating these particular tasks had been completed.

The Environmental Services Manager (who had started employment at the home during this inspection) confirmed on November 22, 2011 that routine and preventative maintenance had likely been carried out, however no documentation was found to support this completion of tasks, including the details of what was done, when and by whom and what systems and equipment had been monitored on a routine basis as required in the policy.

2. The policy Admission/Re-Admission (RCM02-02-02 updated August 2011) included a Re-admission Checklist Form.

The staff were using the home's Re-admission Checklist Form RCM last updated on October 2008 for residents returning from a hospitalization which stated: All shifts for the next 72 hours will chart vitals and complete Head to Toe Skin Assessment when residents are re-admitted to the home.

A resident sustained an injury in the home and was hospitalized and readmitted to the home.

A record review and interview with Registered Practical Nurse confirmed the resident had vitals taken 3 times, not 9 times as required in the 72 hours after re-admission and there was no Head to Toe Skin Assessment completed upon the resident's return to the home.

3. The policy and procedure Falls Prevention Assessment and Management (RCM04-04-01) indicated "direct care staff will be aware of Client Mobility Review before moving the resident."

Four Personal Support Workers were interviewed and all revealed they were not aware of the "Client Mobility Review" and therefore did not use the Review before moving residents.

4. The policy and procedure Bowel Elimination Records (RCM04-03-05 updated August 2011) indicated the Personal Support Workers were to document for each shift on all of their assigned residents, bowel elimination or lack of bowel elimination in the space provided on the Monthly Bowel Elimination Record. The policy specifically states "no blank spaces are to be left".

This documentation had not been completed for two residents. There were 18 blank spaces noted in one week on the Bowel Elimination Record for one resident and seven blank spaces in two weeks for the other resident.

A Registered Practical Nurse, a Registered Nurse and Assistant Director of Care confirmed the resident's documented responses to bowel interventions were missing and the expectation was the responses should be documented.

[O.Reg. 79/10, s.8(1)(b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

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).

Findings/Faits saillants :

1. The licensee did not ensure that reassessments and resident responses to interventions were documented regarding oral hygiene for a resident.

The Resident Assessment Protocol dental assessments in the last three quarters did not include documentation of the number of times dental care was actually provided as compared to the care plan interventions, whether the interventions were effective or the resident's responses to the interventions.

2. The licensee did not ensure any actions taken with respect to a resident under the bowel management program, including assessments, reassessments, interventions and the responses to interventions were documented for two identified residents:

a) A resident did not have documented responses to bowel interventions. The resident's Bowel Elimination Records had missing information regarding responses to bowel interventions.

A Registered Practical Nurse and Assistant Director of Care confirmed there were missing documented responses to bowel interventions in the two months reviewed.

b) A second resident did not have documented assessments, interventions or responses to interventions regarding bowel management.

There was no documentation on the Bowel Elimination Record or the progress notes of any bowel movements or interventions attempted for bowel movements in an 11 day period.

There were no assessments documented in the plan of care regarding a recent change in care, what interventions the resident was receiving for bowel management and the responses to these interventions.

A Registered Nurse and Registered Practical Nurse confirmed the missing documentation.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The plan of care did not set out clear direction to the staff who provided continence care to a resident.

The bladder section of the plan of care indicated the resident will be "dry and comfortable with routine toileting and will regain continence of urine with a bladder retraining program to be achieved by next quarter".

There were no interventions in the plan of care to indicate what the bladder retraining program consisted of and what the staff were expected to do to assist the resident in regaining continence.

Personal Support Workers indicated they were unaware of a bladder retraining program for this resident.

The Assistant Director of Care confirmed if a resident is on a retraining program the details of the program should be included in the interventions.

2. The plan of care did not set out clear directions to the staff providing care to a resident regarding use of bed-rails.

The Falls section of the most current plan of care, found both in the computer system and the Personal Support Workers' flowsheet binder, indicated a different number of bed-rails to be used compared to what was actually being used according to Personal Support Workers and a Registered Practical Nurse.

Registered Practical Nurse confirmed the plan of care information was incorrect.

[LTCHA, 2007 S.O.2007, c.8, s.6(1)(c)]

3. The licensee did not ensure that the staff who provided direct care to a resident were kept aware of the contents of the resident's plan of care.

A staff interview with a Personal Support Worker revealed the plan of care the Personal Support Workers used was located in the flow sheet binder they used for documentation.

Observation of the flow sheet binder revealed the 'kardex' generated from the plan of care in the computer system was the document used by the Personal Support Workers.

A record review on November 15, 2011 revealed the plan of care and the kardex were last updated September 17, 2011 in the computer system. The kardex that was printed and made available to the Personal Support Workers in the flowsheet binders was printed on May 11, 2011.

A staff interview with the Registered Nurse revealed the most current plan of care for Personal Support Workers should be in their documentation binders. The kardex was to be reprinted when there was a change in the resident's plan of care. The Registered Nurse verified the date of the posted kardex for this resident to be May 11, 2011 and therefore not the most recent plan of care information.

[LTCHA, 2007 S.O.2007, c.8, s.6(8)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the plan of care sets out clear direction to staff and that the staff are kept aware of the contents of the plan of care, to be implemented voluntarily.

WN #4: 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).

Findings/Faits saillants :

1. The licensee did not ensure the resident's plan of care was based on an interdisciplinary assessment of continence for a resident.

The last Resident Assessment Protocol (RAP) assessment indicated the resident was frequently incontinent of bladder.

The plan of care for bladder incontinence did not include new interventions to address new issues of bladder incontinence for this resident. The plan of care included an outcome of being on a retraining program however the interventions did not address what this program would involve.

The Assistant Director of Care confirmed the plan of care was not based on the documented assessment and if a toileting program was used for this resident the expectation would be the details of the program would be included in the plan of care for that resident.
[O.Reg. 79/10, s.26(3)8.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care is based on an interdisciplinary assessment with respect to continence care, including bladder and bowel elimination, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following subsections:

s. 229. (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/Faits saillants :

1. The licensee did not ensure each resident admitted to the home was screened for tuberculosis within 14 days of admission unless the resident had already been screened at some time in the 90 days prior to admission.

In a record review of five residents, four residents (80%) were not screened for tuberculosis within 14 days of admission or 90 days prior to admission.

In an interview, the Assistant Director of Care confirmed the above residents had not had their tuberculosis screening tests within 14 days of admission or 90 days prior to their admission.
[O.Reg. 79/10, s.229(10)1]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident had been screened at some time 90 days prior to admission, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information

Specifically failed to comply with the following subsections:

s. 225. (1) For the purposes of clause 79 (3) (q) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 79 of the Act includes the following:
1. The fundamental principle set out in section 1 of the Act.
2. The home's licence or approval, including any conditions or amendments, other than conditions that are imposed under the regulations or the conditions under subsection 101 (3) of the Act.
3. The most recent audited report provided for in clause 243 (1) (a).
4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service.
5. Together with the explanation required under clause 79 (3) (d) of the Act, the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act. O. Reg. 79/10, s. 225 (1).

Findings/Faits saillants :

1. The Licensee did not post in the home and communicate to residents the most recent audited reconciliation report. On November 14, 2011 the home's Business Manager confirmed the home did not have a copy of the report. During the inspection the home obtained a copy of the "Independent Auditors' Report" from the home's corporate office and posted it.
[O.Reg. 79/10, s.225(1)3.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee failed to ensure stored drugs complied with manufacturer's instruction for the storage of drugs i.e. expiration dates.

The government stock medication was located on the third floor. On November 21, 2011 the following outdated medication was found on the shelves:

Baxedin (antiseptic) 4 expiry date November 2010 and 1 expiry date November 2009
Almagel 1 bottle expiry date April 2010
Alugel 1 bottle expiry date July 2011
Mucillium 1 bottle expiry date September 2011
Vitamin C 2 bottles expiry date September 2011
Cepacol lozenges 1and 1/2 boxes expiry date February 2011
Bronchophen expectorant 7 bottles expiry date March 2011
Forza-10 expiry date 1 bottle October 2011.

[O.Reg. 79/10, s.129(1)(a)(iv)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee did not ensure a written record was prepared including the names of the people who participated in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents. This missing documentation was confirmed by the Regional Manager of Quality and Education.
[O.Reg. 79/10, s.99(e)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The home did not maintain a record including the names of the persons who participated in evaluations for improvements made under the homes quality improvement program (Vision for Improving Performance). This lack of documentation was confirmed by the Director of Care and the Regional Manager of Quality and Education.
[O.Reg. 79/10, s.228(4)ii]

2. The improvements made to the quality of accommodation, care, services, programs and goods provided to residents had not been communicated to the Resident's Council, and had only been communicated in part to the Family Council. The information had not been included in the minutes of the meetings of these Councils and the lack of this communication was confirmed by the Director of Care and the Regional Quality and Education Manager.
[O.Reg. 79/10, s.228(3)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints
Specifically failed to comply with the following subsections:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee did not ensure a documented record was kept in the home regarding final resolution of complaints, the date on which any response was provided and a description of the response for residents' issues brought forward during food committee meetings. The residents' complaints and suggestions were recorded in the minutes with an action plan, however the follow-up completed and the response to the residents were not documented. This lack of documentation was confirmed by the Food Services Manager on November 15, 2011.
[O.Reg. 79/10, s.101(2)(d) and (e)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey
Specifically failed to comply with the following subsections:

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

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

Findings/Faits saillants :

1. The licensee did not ensure the resident satisfaction survey results and actions taken to improve the home were made available to residents and their families.

The last survey was completed early in 2011 and the results were presented to Family Council in September 2011, however they were not made available to all family and residents. There were documented planned actions associated with concerns brought up in the survey, however the actual actions taken to make improvements were not documented or made available to residents or their families.

This lack of communication of information was confirmed by the Director of Care and the Regional Manager of Quality and Education.
[LTCHA, 2007 S.O. 2007, c.8, s.85(4)(c)]

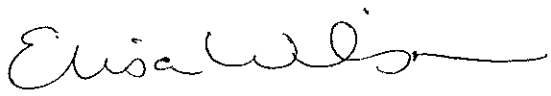
2. The Home did not seek the advice of Residents' Council or Family Council in developing the resident satisfaction survey. This was confirmed by both Councils, the staff liaisons of both Councils, the Director of Care and the Regional Manager of Quality and Education. The Vision for Improving Performance team at the home has prepared a process for seeking advice from the Councils to be implemented before the 2012 survey.
[LTCHA, 2007 S.O. 2007, c.8, s.85(3)]

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

CORRECTED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 r. 8.	CO #001	2011_095105_0018	135

Issued on this 12th day of December, 2011

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



Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ELISA WILSON (171), BONNIE MACDONALD (135), CAROLE ALEXANDER (112), DIANNE WILBEE (170), JUNE OSBORN (105)
Inspection No. / No de l'inspection :	2011_067171_0028
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
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Licensee / Titulaire de permis :	DEVONSHIRE ERIN MILLS INC. 195 DUFFERIN AVENUE, SUITE 800, LONDON, ON, N6A-1K7
LTC Home / Foyer de SLD :	LANARK HEIGHTS LONG TERM CARE CENTRE 46 LANARK CRESCENT, KITCHENER, ON, N2N-2Z8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~DEBBIE BOAKES~~ HILDY NICKEL

To DEVONSHIRE ERIN MILLS INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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).

Order / Ordre :

The licensee must ensure that any policy, procedure or system that the long term care home has put into place is complied with, specifically with regards to the following:

a) The Bowel Management program regarding the Bowel Elimination Record documentation
b) The Falls Assessment and Management policy regarding the Client Mobility Review
c) The Admission/Readmission policy regarding the use of the Readmission checklist

Grounds / Motifs :

1. The policy and procedure Bowel Elimination Records (RCM04-03-05 updated August 2011) indicated the Personal Support Workers were to document for each shift on all of their assigned residents, bowel elimination or lack of bowel elimination in the space provided on the Monthly Bowel Elimination Record. The policy specifically states "no blank spaces are to be left".

This documentation had not been completed for two residents. There were 18 blank spaces noted in one week on the Bowel Elimination Record for one resident and seven blank spaces in two weeks for the other resident.

A Registered Practical Nurse, a Registered Nurse and Assistant Director of Care confirmed the resident's documented responses to bowel interventions were missing and the expectation was the responses should be documented. (171)

2. The policy and procedure Falls Prevention Assessment and Management (RCM04-04-01) indicated "direct care staff will be aware of Client Mobility Review before moving the resident."

Four Personal Support Workers were interviewed and all revealed they were not aware of the "Client Mobility Review" and therefore did not use the Review before moving residents. (105)

3. The policy Admission/Re-Admission (RCM02-02-02 updated August 2011) included a Re-admission Checklist Form.

The staff were using the home's Re-admission Checklist Form RCM last updated on October 2008 for residents returning from a hospitalization which stated: All shifts for the next 72 hours will chart vitals and complete Head to Toe Skin Assessment when residents are re-admitted to the home.

A resident sustained an injury in the home and was hospitalized and readmitted to the home.

A record review and interview with Registered Practical Nurse confirmed the resident had vitals taken 3 times, not 9 times as required in the 72 hours after re-admission and there was no Head to Toe Skin Assessment completed upon the resident's return to the home. (135)

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

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that any actions taken with respect to a resident under the following programs, including assessments, reassessments, interventions and the resident's responses to intervention, are documented.

a) the dental care program
b) the bowel management program

The plan shall be submitted to Elisa Wilson by email to elisa.wilson@ontario.ca by January 6, 2012.

Grounds / Motifs :

1. The licensee did not ensure any actions taken with respect to a resident under the bowel management program, including assessments, reassessments, interventions and the responses to interventions were documented for two identified residents:

a) A resident did not have documented responses to bowel interventions. The resident's Bowel Elimination Records had missing information regarding responses to bowel interventions.

A Registered Practical Nurse and Assistant Director of Care confirmed there were missing documented responses to bowel interventions in the two months reviewed.

b) A second resident did not have documented assessments, interventions or responses to interventions regarding bowel management.

There was no documentation on the Bowel Elimination Record or the progress notes of any bowel movements or interventions attempted for bowel movements in an 11 day period.

There were no assessments documented in the plan of care regarding a recent change in care, what interventions the resident was receiving for bowel management and the responses to these interventions.

A Registered Nurse and Registered Practical Nurse confirmed the missing documentation. (171)
2. The licensee did not ensure that reassessments and resident responses to interventions were documented regarding oral hygiene for a resident.

The Resident Assessment Protocol dental assessments in the last three quarters did not include documentation of the number of times dental care was actually provided as compared to the care plan interventions, whether the interventions were effective or the resident's responses to the interventions. (171)

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the

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

Director

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

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 2nd day of December, 2011

Signature of Inspector / Signature de l'inspecteur : Elisa Wilson

Name of Inspector / Nom de l'inspecteur : ELISA WILSON

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

Ontario

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

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

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

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

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

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

Facsimile: 519-675-7685

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

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

Télécopieur: 519-675-7685

Date(s) of inspection/Date de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 3, 5, 7, 8, 9, 10, 14, 15, 16, 17, 18, 21, 22, 23, 28, 29, Dec 2, 2011	2011_067171_0028	RQI- L-001730-11

Licensee/Titulaire de permis
Devonshire Erin Mills Inc., 195 Dufferin Avenue Suite 800, London, Ont. N6A 1K7

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

Lanark Heights LTC Centre, 46 Lanark Crescent, Kitchener. Ontario N2N 2Z8

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

Elisa Wilson # 171, Carole Alexander # 112, June Osborn #105, Bonnie MacDonald #135, Dianne Wilbee #170

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ORDER #/ GENRE DE MESURE/ORDRE NO	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg.79/10, s. 68(2)(C)	WN, CO #008 WN, CO #005	2010_135_2917_06Dec173056 2011_135_2917_17Mar164140	135

Issued on this 2nd day of December, 2011

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

Elisa Wilson