Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 9, 2015	2014_168202_0026	T-54-14	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

LEISUREWORLD CAREGIVING CENTRE - BARRIE
130 OWEN STREET BARRIE ON L4M 3H7

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

VALERIE JOHNSTON (202), DIANE BROWN (110), JUDITH HART (513)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 12, 13, 14, 17, 18, 20, 21, 24, 25, 26, 2014.

During the course of this inspection the following complaint was completed: T-323-14.

During the course of the inspection, the inspector(s) spoke with administrator, director of care (DOC), assistant director of care, dietitian, food service director (FSD), environmental services manager (ESM), resident relations coordinator, director of resident programs, registered nursing staff, food service workers, cook, personal support workers (PSW), housekeeping aide, laundry aide, residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

16 WN(s)
4 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

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; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(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/Faits saillants :

1. The licensee has failed to ensure that residents are offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident/SDM if payment is required.

Resident and power of attorney (POA) interview revealed that resident #03 had teeth extracted on an identified date and after a post operation dental visit on a subsequent identified date, the home did not offer any further dental assessments to date. The POA expressed concerns around lack of oral care and teeth brushing at the resident care conference.

Interview with the administrator confirmed that the home does not offer a annual dental assessment. [s. 34. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident/SDM if payment is required, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all menu items are prepared to the planned menu.

On November 20, 2014, the lunch meal entrées were observed and included crab salad on a croissant with beets as a menu choice.
Record review revealed that the recipe included imitation crab, fresh onion, celery, red pepper, lemon juice, dry mustard, mayonnaise, and white pepper in the crab salad.
The crab salad was observed to have no fresh onion, celery, or red pepper. The crab salad was taste tested and crab and a mayonnaise dressing was identified.
An interview with the cook who prepared the menu item confirmed that the crab salad did not include the fresh onions, celery and red pepper.
The food service director was unaware that the recipe has been altered and revealed that staff are expected to follow recipes as provided.
Sunday, November 23, 2014, the posted menu included italian mixed vegetables at lunch and scandinavian mixed vegetables at dinner. Staff and record review confirmed that these are two different vegetables. Resident interview revealed the same italian mixed vegetable was served at both lunch and supper. An interview with the food service director revealed an unawareness of the change in vegetable and confirmed that staff had not documented any changes on the weekend menu. Resident interview confirmed that menu changes happen frequently, especially on weekends. The resident indicated that this has been reported to management and the DOC confirmed awareness of food and menu related issues. [s. 72. (2) (d)]

2. The licensee has failed to ensure that menu substitutions are documented on the production sheet.

On November 17, 2014, the posted menu at lunch was changed from corned beef on rye to corned beef on white bread. Resident interview identified that menu substitutions are frequent. Record review and interview with the food service director confirmed that the change in menu was not documented on the production sheet or menu substitution form as required.
On Sunday, November 23, 2014, the posted menu included italian mixed vegetables at lunch and scandinavian mixed vegetables at dinner. Staff and record review confirmed that these are two very different mixed vegetables. Resident interview revealed the same italian mixed vegetable was served at both lunch and supper. Record review revealed no documentation of the menu substitution on the production sheet and the food service director was unaware of the weekend menu change. The resident indicated that frequent menu changes have been reported to management and the DOC confirmed awareness of this issue. [s. 72. (2) (g)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all menu items are prepared to the planned menu and that menu substitutions are documented on the production sheet, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).**

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes communication of the daily menu to residents.

On November 20, 2014, the lunch menu posted was crab salad plate with croissant and beets. Record review and interviews confirmed that this menu item had been previously served and included crab salad on lettuce with potato salad, tossed salad and a croissant. Resident interview identified that the menu posted was not what was served and that this happens frequently in the home.
The lunch entree served was crab salad on a croissant with beets. The food service director confirmed that the menu posted was not what was served, however, residents had requested crab on a croissant at a food committee meeting.
On Sunday, November 23, 2014 the posted menu included italian mixed vegetables at lunch and scandinavian mixed vegetables at dinner. Staff and record review confirmed that these are two very different mixed vegetables. Resident interview revealed that italian mixed vegetables were served at both lunch and dinner with no communication to the residents. The food service director was unaware that the menu was not followed on Sunday. Resident interview confirmed that menu changes happen frequently, especially on weekends. The resident indicated that this has been reported to management and the DOC confirmed awareness of food and menu related issues. [s. 73. (1) 1.]

2. The licensee has failed to ensure that the dining and snack service includes a review of the meal and snack times by the Residents' Council.

Record review and an interview with the Residents' Council assistant confirmed that Residents' Council had not reviewed the dining and snack service including a review of the meal and snack times. [s. 73. (1) 2.]

3. The licensee has failed to ensure that residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance.

On November 12, 2014, initial day of the unannounced inspection, resident #20 was observed to be served a pureed entree in advance of assistance being provided. The resident did not initiate eating the meal on his/her own. Resident is known to staff to require total assistance with feeding unless the resident is having a good day. Resident's plan of care related to eating identified that the resident required total assistance for eating. An interview with the DOC confirmed that residents who require total assistance are served their meal with their table mates for a fine dining experience, however, the food would not be placed in front of a resident until a PSW is available to assist the resident. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes communication of the daily menu to residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Resident #41's written plan of care directs registered staff to administer a medication subcutaneously every morning and in the evening. Staff and resident interviews and record review indicated that on an identified date, resident #41 was administered the incorrect medication subcutaneously in the morning and not what had been prescribed.

An interview with an identified registered nurse (RN) indicated that on an identified date, he/she was assigned to mentor a nursing student. The nursing student replaced resident #41's medication from the medication fridge. The RN confirmed that he/she did not observe the student replace the medication.

On an identified date, prior to administering the resident's evening medication, the RN indicated that medication had been replaced in error and was not what had been ordered by the physician. The RN indicated that he/had then assumed that the resident had received the wrong insulin earlier that morning and called the physician, assessed the resident and reported the incident to the DOC. The DOC investigated the incident and confirmed a medication error had occurred on the above identified date. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #5: 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:

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. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee fully respected and promoted the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.
On November 25, 2014, the inspector was conducting an interview in an identified resident's room with the door closed. A PSW staff opened the resident's room door, entered the resident's bathroom and left the room without first knocking upon entry, without acknowledging the resident in the room or closing the door when he/she left. An interview with the identified staff confirmed that he/she had not knocked before entering the residents room. Both residents present expressed that it bothers them that staff do not knock and will enter resident's rooms without knocking. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the 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 is fully respected and promoted.

On November 14, 2014, the inspector observed licensee report #2011_125_2584_21Apr100656 dated April 29, 2011, posted in the home. The report exposed personal health information of several residents. The administrator confirmed unawareness of the above and indicated that the report would have been posted over two years ago, prior to her employment with the home. [s. 3. (1) 11. iv.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

During the course of this inspection the following was observed:
November 17, 2014, at 11:15 a.m., the third floor east/west hallway contained two wheelchairs, two bedside tables, a hoyer mechanical lift, soiled linen cart and chairs obstructing both sides of the hallway;
November 20, 2014, at 2:40 p.m., the third floor north/south hallway contained a hoyer mechanical lift, a bedside table and chair, two wheelchairs, four bin soiled linen cart obstructing both sides of the hallway.
Registered staff confirmed the above and indicated that residents did not have access to the hand rails on either sides of the hallway causing a safety risk. An interview with the administrator indicated that one side of the hallway should always be kept clear of equipment to promote a safe and secure environment for all residents. [s. 5.]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care set out clear directions to staff and others who provide direct care to the resident.

Resident #03's written plan of care requires one staff assist for personal hygiene and oral care. Interviews with the DOC and a registered nurse indicated that all residents are to be provided oral care with a toothbrush, unless indicated otherwise. Interviews with the day and evening PSW staff revealed that they use toothettes to clean the resident's teeth. One PSW indicated that the resident's teeth are in such poor condition that she uses a toothette as resident's gums would bleed if she used a toothbrush.
Record review and POA interview revealed that at the annual care conference the POA raised a concern that the resident's teeth are not always clean.
An interview with registered staff and DOC confirmed that the written plan of care requires staff to brush resident #03's teeth with a toothbrush. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the written plan of care set out clear directions to staff and others who provide direct care to the resident.

Resident and staff interviews confirmed that two residents in the home have a mutually agreeable relationship and often close to the door to the room. Resident interview revealed that some staff have acknowledged their need for privacy, by way of allowing a closed door while another staff wanted the door open. Resident expressed that he/she becomes upset when he/she is made to keep the door open, feeling like a child and that he/she was doing something wrong when requesting to have the door closed.
An interview with the DOC revealed that these two residents have the right to their privacy and the door closed as requested. The DOC also identified other approaches to support residents need for privacy and confirmed that the written plan of care had not set out any directions to staff and others who provide direct care to the resident on the importance and approaches to maintaining resident #15 and his/her companion's privacy. [s. 6. (1) (c)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's medication management-drug destruction policy, V3-930, dated April 2013, is complied with.

The above mentioned policy directs staff to destroy and dispose of discontinued medications safely and securely. The policy indicated that discontinued drugs are to be stored in an area separate from drugs that are currently available for administration.

Resident #41's written plan of care directs registered staff to administer an identified medication in the a.m. Staff interviews and clinical record review indicated that on an identified date, in the a.m., the resident received the wrong medication. Registered staff interviews indicated that on an identified evening, a nursing student replaced the resident's medication from the medication fridge. The RN indicated that he/she did not oversee the nursing student replace the medication, however, at the time of incident resident #41 was the only resident on the unit using this type of medication. On an identified date, in the evening, the same identified RN indicated that upon checking the resident's medication prior to administration, he/she realized the medication was incorrect for this resident and reported the incident to the DOC. Registered staff interviews indicated that the medication had been used in error, and that the medication had been prescribed for a deceased resident, who passed away two months prior. A review of of the deceased resident's plan of care directed staff to discontinue all medications on an identified date. Registered staff indicated that all of resident #42's medications were disposed of; however, one medication remained in the medication fridge. The DOC confirmed in an interview that the home's medication management-drug destruction policy, V3-930, dated April 2013, had not been complied with resulting in the above noted medication error of resident #41. [s. 8. (1) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings

Specifically failed to comply with the following:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care; O. Reg. 79/10, s. 12 (2).
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).
(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).
(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).
(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so.

Interviews with resident #41, #03 and #15 indicated that they do not have a chair in their room and would like one. Resident #41 indicated that he/she has requested to have a chair in his/her room for comfort and to allow family to use when visiting. An interview with the administrator indicated that residents are only permitted to have a chair in their room if space permits. The administrator confirmed that resident #41 has requested a chair in his/her room, however, there is no space to allow for a chair and staff would not be able to provide her care without a health and safety risk. [s. 12. (2) (e)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On November 21, 2014, the following raised toilet seats in rooms #201 and #207 were observed to be loose and resting on the toilet. The raised toilet seat in room #307 was loose, and the clamp used to tighten the toilet seat was broken. An interview with the ESM confirmed that the raised toilets seats in the above rooms were loose and posed a safety risk for residents when using the toilet. The ESM indicated that new raised toilet seats with tightening clamps and arm rests were available in the home and would be installed immediately. [s. 15. (2) (c)]

WN #11: 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:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a response was provided in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Record review revealed that at the July 11, 2014 Residents' Council meeting a concern was raised that residents were not aware if there was availability of snacks and beverages on the unit outside of meals and nourishment time. Staff interviews and record review confirmed that a response was not provided in writing to Residents' Council. [s. 57. (2)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On November 14, 2014, the inspector observed the following inspection report was not posted in the home:
Report #2013_162_109_0037, dated October 15, 2013.
The absence of the report was confirmed in an interview with the administrator. [s. 79. (3) (k)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that at least once in every year, a survey will be taken of the residents and their families to measure their satisfaction with the home and care, services, programs and goods provided at the home.
Staff interviews and a review of the home's current process for determining satisfaction revealed that the home uses the standardized stage 1 questions from abaqis plus three additional questions regarding satisfaction with the facility and likelihood of recommendation by residents and family members.
A record review confirmed that the home's current survey is an audit and does not determine satisfaction with all programs and services, such as occupational therapy, physiotherapy, continence care, and skin and wound program. [s. 85. (1)]

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

Record review and an interview with the Residents' Council assistant revealed that the satisfaction survey was not developed with the advice of the Residents' Council and Residents' Council advice was not obtained when acting on the surveys results. The Administrator confirmed that the satisfaction survey is a standardized survey from their corporate office and that residents were not consulted in the development of the survey. [s. 85. (3)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt as follows: 3(i) a response shall be made to the person who made the complaint.

Record review and POA interview revealed that at the annual care conference the POA raised a concern that resident #03's teeth are not always clean. A concern form was submitted to the DOC for follow-up. Record review and POA interview revealed that a response back to the POA was not provided. An interview with the DOC revealed that he/she was unable recall or demonstrate that a response was not provided to resident #03's POA. [s. 101. (1) 3.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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 O. Reg. 79/10, s. 129 (1).
(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 that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

On November 20, 2014, inspector observed the contents of the top drawer of the second floor medication cart. The contents in the medication cart included money in a small zipped bag and one packet of cigarettes, with a lighter. Interviews with the charge nurse and the DOC confirmed that the change and cigarettes should not be stored in the medication cart. [s. 129. (1) (a) (i)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During the course of this inspection the following was observed:
November 12, 2014, the call bell cord was lying on the floor in the tub room on third floor;
November 17, 2014, a toilet brush, two bed pans, one slipper pan and a urinal were lying together under the sink in the shared washroom of room #203 and #204;
November 18, 2014, resident #18's catheter bag was lying on the floor beside bed;
November 21, 2014, resident #18's blue hair comb was lying on the floor beside the bathroom toilet.
Interviews with direct care staff confirmed the above findings. Staff indicated that resident's personal care equipment such as bed pans and urinals are kept under the sink in the bathroom of each resident's room as there is no other space to store them. An interview with the DOC confirmed that storing of resident's personal care equipment is a concern and that hooks are being installed in resident rooms to store the equipment. [s. 229. (4)]

Issued on this 9th day of January, 2015

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

Original report signed by the inspector.