Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 2, 2015	2014_171155_0027	T-000056-14	Resident Quality Inspection

Licensee/Titulaire de permis

2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP
302 Town Centre Blvd. Suite #200 MARKHAM ON L3R 0E8

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

LEISUREWORLD CAREGIVING CENTRE - CREEDAN VALLEY
143 MARY STREET CREEMORE ON L0M 1G0

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

SHARON PERRY (155), DOROTHY GINTHER (568), NUZHAT UDDIN (532), TAMMY SZYMANOWSKI (165)

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 3, 4, 5, 6, 7, 10, 12, 13, 14, and 18, 2014.

Two complaint inspections (log numbers 299-14 and 635-14) were done concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with Executive Director, Acting Director of Care, Associate Director of Care, Food Services/Housekeeping Manager, Maintenance Manager, Maintenance Man, Resident Relations Coordinator, Cook, 2 Dietary Aides, Registered Dietitian, Recreation Aide, Laundry Aide, Housekeeper, Registered Nurse, 4 Registered Practical Nurses (RPN), 14 Personal Support Workers (PSW), Family Council Representative, Resident Council Representative, 3 Family members, and 40+ Residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

21 WN(s)
12 VPC(s)
8 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 LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and 2007, c. 8, s. 11. (1).
(b) an organized program of hydration for the home to meet the hydration needs of residents. 2007, c. 8, s. 11. (1).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that there was an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

Nine residents interviewed reported that they have to wait for meals and that meal service was frequently late for second sitting. Residents and staff interviewed identified that meal service did not occur on time on a regular basis resulting in extended meal service for first and second sitting.

On November 3, 2014, lunch meal service was observed by inspectors #155 and #532 to be extended. At 1324 hours the second sitting had not commenced and a resident was observed banging the table asking for a meal. One resident stated "I am just looking for something to eat". The last entrée was served to a resident at 1345 hours, 45 minutes after the scheduled meal time and desserts had not yet been served at this time.
On November 3, 2014, a bingo activity was scheduled in the dining room for 1400 hours however, residents were still eating in the dining room and the activity was relocated to the front lounge.

Residents confirmed that activities were affected as a result of extended meal services and one resident reported that they missed scheduled activities because they were still in the dining room eating.
One resident reported that residents on the second sitting for meals have waited twenty minutes past the scheduled meal time before being portered into the dining room as the first sitting was not on time. It was often forty-five minutes passed the commenced meal time by the time entrees were served.

One resident reported that they wait 30 minutes or longer for meals and it was often dependent on the staffing for the day.
Residents reported that the extended meal service did not provide enough time between meals and nourishment times. On November 13, 2014 the last residents on second sitting were observed finishing in the dining room at 1005 hours. At 1025 hours Personal Support Workers started passing the nourishments to residents that are on second sitting. A resident and Personal Support Workers confirmed that the nourishment time was too close to the finishing of meal times.

Several residents interviewed reported that they feel rushed and hurried during meal service. One resident reported that they felt rushed and staff take the milk and water off the table before being finished.
One resident reported that they feel rushed, staff clear the table before being finished and if they look away for a minute their coffee and milk are gone even if they were not finished.

Six of eight residents interviewed reported that they feel rushed during their meals and staff often clear tables prior to finishing their meals. It was reported that extended meal service and residents feeling rushed was raised at the last Residents Council meeting.

On November 13, 2014, staff were observed clearing and wiping tables with residents still eating. At 0954 hours three residents were sitting at an identified table, one resident finishing their drinks and one resident finishing their breakfast meal when a Personal Support Worker cleared and wiped the table with the three residents sitting at the table. A review of dietary minutes dated July 29, 2014, indicated that tables were being reset for second sitting when residents were still eating at the table.

The Food Service Manager confirmed that the timing of meal service was extended and that concerns have been raised related to residents being rushed during meal service. [s. 11. (1) (a)]

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. 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The Homes' Policy #V3-239 for Continence Management Program - Bladder and Bowel outlines the purpose of the program as being to ensure that the continence needs of residents are met and evaluated within 7 days of admission, quarterly and with any change in condition that affects continence.

Resident #43's admission Minimum Data Set (MDS) assessment indicates that the resident was continent of both bowel and bladder. The first quarterly MDS indicates that the residents' continence had declined such that they were now usually incontinent for both bowel and bladder, with incontinent episodes once a week or less.

There was no quarterly continence assessment found during a review of resident #43's clinical record. The Associate Director of Care confirmed that at quarterly continence assessment should have been completed for resident #43. [s. 8. (1) (b)]

2. The Homes' Policy #V3-450 called Diabetes Management-Blood Glucose Monitoring, revised April 2013 states "individual glucometers are to be provided for each resident requiring regular blood glucose monitoring".

On November 13, 2014 during observation of a medication pass the following was noted:

Resident #52 was to have their blood glucose level monitored. The registered staff took a glucometer out of the medication cart, checked the resident's blood glucose level and shared the results of the test with the resident. The registered staff continued with administering oral medications to resident #52. The registered staff member was not observed cleaning or disinfecting the glucometer before or after nor did they wash their hands or use gloves as indicated in the policy.

Resident #53 also required regular blood glucose monitoring and the same registered staff was observed using the same glucometer that they had used for resident #52. The registered staff was not observed cleaning or disinfecting the glucometer before or after or washing their hands, and was not observed using gloves.

When the registered staff was asked about the practice of using the same glucometer between two different residents, they confirmed that was their mistake.

The Acting Director of Care confirmed that this was not the practice of the home and all residents requiring regular blood glucose monitoring were provided with their own individual glucometers. Residents requiring regular blood glucose monitoring were noted to have their own labelled glucometers on the medication cart. The Acting Director of Care further confirmed that individual monitors were kept in the medication cart and the expectation was that the registered staff used those assigned monitors to check the blood glucose level .

3. Policy number V3-920 titled Medication Management Controlled and Narcotic Medication, revised Apr 2013, states under Administration: that "the nurse is to complete the documentation on the controlled and narcotic records at the time the medication is removed from the container".

The following was observed during a medication pass on November 13, 2014:
A registered staff was observed removing a pill from the blister package and placing it in their hand for resident #61 and administering the medication to the resident. No count was done at the time the medication was removed from the blister package.

The registered staff was observed to take a pill from the blister package and place it in their hand for resident #27 and then administered the medication to the resident. No count was done at the time of the medication was removed from the blister package.

The registered staff was further observed taking narcotics out of the blister packages for

resident #23, #25, #26, and #51 and placed them in their hand and then administered them to the residents. No count was done at the time the medication was removed from the blister packages.

When the registered staff was asked about the practice of not counting the narcotics at the time the medication was removed, the registered staff shared that they prefer to leave it until the end of the medication pass because the count won't change for the resident. In addition they indicated there was no space on the cart to keep the binder and therefore, they were not able to complete the count.

The Acting Director of Care confirmed that this was not the practice of the home and the expectation was to complete the controlled and narcotic medication count at the time of administration and confirmed that the registered staff was not complying with the Home's policy and procedures. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the physical device is applied in accordance with the manufacturer's instructions.

Instructions provided by Shoppers Home Health Care for the application of the two types of seat belts being used in the home indicates that in order to be effective, any belt must be positioned across the hips, not across the abdomen and it should not be too loose to allow the client to slide under the belt or too tight to irritate bony prominences or soft tissue. They indicate that the space should be just enough for two fingers to fit between the seat belt and the pelvic crest. The Home's policy for Mechanical Restraint and PASD, V3-1340, states that the Personal Support Worker will ensure that the resident is seated properly in the chair and any seat belt used is spaced no more or less than 2 finger widths away from the residents' body.

On November 10, 2014 resident #14 was observed sitting in their wheelchair. The resident had a seat belt applied across the hips but it appeared to be quite loose. This inspector found that there was more than a four finger width between the belt and the residents' body. A staff member confirmed that the belt was too loose and adjusted the seat belt immediately.

On November 12, 2014 resident #14 was observed sitting in their wheelchair at the side of the bed. The resident had a seat belt applied across their hips. This inspector found that the space between the residents' body and the belt was greater than three finger widths. A staff member confirmed that the seat belt was too loose.

Resident #14's seat belt was not being applied in accordance with manufacturer's instructions. [s. 110. (1) 1.]

2. On November 07, 2014 resident #12 was observed sitting in their wheelchair. The resident had a seat belt that was twisted and positioned loosely across the hips. The inspector found that there was enough space for the entire hand to fit between the belt and the pelvic crest.
A Personal Support Worker confirmed that the seat belt was twisted and positioned loosely on the resident. The PSW then unbuckled the belt, untwisted and tightened the belt.

On November 10, 2014 resident #12 was noted to have their seat belt on however it was

twisted and was positioned loosely. There was enough space for the entire hand to fit between the belt and the pelvic crest. The PSW reported that the seat belt was twisted under the resident but was unsure how tight the belt should be. The staff member was observed untwisting the belt and reapplying it loosely.
The Registered Practical Nurse confirmed that the seat belt was not applied correctly . The RPN took the belt off and tightened it. They confirmed that it was not applied in accordance with the manufacturer's instructions or the policy of the home. [s. 110. (1) 1.]

3. The licensee has failed to ensure that staff release the resident from the physical device and reposition at least once every two hours.

Clinical record review revealed that resident #14 has a physical restraint in the form of a seat belt for safety. The seat belt will be on at all times when the resident is up in the wheelchair. Safety checks will occur hourly while wearing the seat belt and the resident will be repositioned every two hours.

Resident #14 was observed sitting up in their wheelchair on November 13, 2012 between 09:30 and 13:30 hours. The resident had a seat belt applied across the hip region. Staff were observed on two occasions to visually check the resident but the physical device was not released and the resident was not repositioned.

Staff interview confirmed that the resident was visually checked to ensure the seat belt was applied but the physical device was not released and the resident was not repositioned. [s. 110. (2) 4.]

Additional Required Actions:

CO # - 003, 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Specifically failed to comply with the following:

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

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

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

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On November 13, 2014 during a medication pass following was observed:

a) Resident #32 had a physician's order for a medication to be given at meal times.

The registered staff did not offer the medication and shared that they won't bother giving the medication as the resident refuses.

Record review for November 13, 2014 revealed that the registered staff documented the medication was refused by the resident, even though it was not offered to them. This was confirmed by the registered staff.

b) Resident #51 had a physician's order for a medication at meal time.
The registered staff was observed offering and administering other medications to the resident but did not offer an identified medication to the resident at meal time.

Record review for November 13, 2014 revealed that the registered staff documented the identified medication was refused by the resident, even though it was not offered to the resident in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

2. The licensee failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

On November 5, 2014 during interviews with 3 PSWs they expressed that they have been instructed by the registered staff and the Director of Care that they are to administer medications to residents if the home is in outbreak and the resident is on isolation. They stated that this included pills and liquid medications. The October 2014 PSW meeting minutes states that a nurse can delegate a PSW to give a pill--if the PSW is already gowned and gloved in the room. You are not legally responsible for that situation--the nurse holds the license. How can a nurse glove, gown and mask all the time as they give meds. PSW's can offer help, especially if they are already gloved and gowned.

The Executive Director confirmed that wrong direction was given to the PSW staff by the Director of Care and that non registered staff should not be administering medications. [s. 131. (3)]

3. The licensee failed to ensure that a member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals:
b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and
c) the staff member who administers the topical does so under the supervision of the

member of the registered nursing staff.

Interview with 3 PSW staff confirmed that they administer topical medications to residents and have not received any training regarding the administration of topicals. The Executive Director confirmed that the home had not provided any education to the PSWs regarding the administration of topicals. The Executive Director agreed that education needed to be provided to the PSWs before they administer anymore topical medications and that they would not be applying them until they have had education. [s. 131. (4)]

4. The licensee failed to ensure that no resident administered a drug to himself or herself unless the administration was approved by the prescriber in consultation with the resident.

a) On November 13, 2014 a Registered Practical Nurse reported that resident #54 self administered medication.

Clinical record review revealed that there was no order from the physician for the self-administration.

b) On November 03, 2014 during lunch meal in the dining room it was observed that resident #44 had medication in a plastic medication cup and three other residents were sitting at the same table.

On November 03, 2014 during lunch meal resident #15 had medications in a plastic medication cup and three other residents sitting at the same table.

Both residents were observed self-administering their medication. Record review revealed that there was no self-administration orders for resident #44 and resident #15.

Personal Support Worker meeting minutes from October 20, 2014 revealed that staff felt that medications were being handed over to the resident and not watched and the same thing occurred with supplements.

The Acting Director of Care confirmed no residents in the home were to self administer a drug to himself or herself unless the administration was approved by the physician. [s. 131. (5)]

Additional Required Actions:

CO # - 004, 006, 007, 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
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. 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:
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents' right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs fully respected and promoted.

Resident #03 was observed November 04, 2014 to be clothed in a manner that did not respect and promote their needs. They were also noted to be unshaven and food was noted on their face.
Resident #03 was observed again on November 06, 2014 with food on their mouth.

The registered nurse confirmed that the resident had food on their mouth and reported that the personal support worker was supposed to clean and wash the resident's face after each meal . [s. 3. (1) 4.]

2. The licensee failed to ensure that the residents' right to have his or her lifestyle and choices fully respected and promoted.

Resident #45 spoke with inspectors # 568 and #532 regarding what they felt was a violation of their rights. They have not been allowed to go out unless supervised. Resident #45 explained that they are aware of and understand the risks of going outside without supervision, but they are willing to accept that responsibility. Resident #45 indicated that they were advised by the Home that despite their willingness to accept the risks they did not feel it was safe for them to go outside unsupervised.

During the Annual Care Conference the resident's desire to go outside was identified and documentation indicates that this cannot be allowed because of the risk.

The home failed to respect and promote the resident's lifestyle and choices. [s. 3. (1) 19.]

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 every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs and every resident has the right to have his or her lifestyle and choices respected, to be implemented voluntarily.

WN #6: 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).

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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(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 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

a) Record review revealed that resident #032 had a behaviour. Interview with two staff confirmed that resident #032 did exhibit this behaviour. Review of resident #032's care plan did not reveal that the resident exhibited this behaviour nor did it set out any strategies or interventions to address the behaviour. The Associate Director of Care confirmed that the care plan did not identify the behaviour and stated the expectation is that it be included on the care plan.

b) The Resident Minimum Data Set(MDS) for resident #03 identified that the resident exhibited mood related behaviours and had communication barriers. The RAP also indicated that this was addressed in the plan of care.
Review of the clinical record for resident #03 revealed that there was no plan of care related to responsive behaviours.

Interview with the Associate Director of Care confirmed that there was no plan of care with goals and interventions related to responsive behaviours for resident #03 and that the expectation would be to have behaviours documented in the plan of care.

c) The Resident Assessment Protocol (RAP) for resident #12 identified that the resident had responsive behaviours. The RAP stated that the behaviour was addressed in the care plan.

Review of the clinical record for resident #12 revealed that there was no plan of care with goals and interventions related to responsive behaviours.

The Associate Director of Care confirmed that there was no plan of care related to responsive behaviour for resident #12. [s. 6. (1) (a)]

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

Resident #32's plan of care indicates they are unable to attend any group activities or dining room service and receives meals in their room. Review of the care plan for eating states that resident #32 gets tray service if they refuse to come to the dining room. Observations on November 5 and 6, 2014 revealed that the resident was in the dining room for lunch meal. Interview with staff confirmed that resident #32 has been eating their meals in the dining room and that the resident often likes to stay in the dining room between meals.

The Associate Director of Care confirmed that the plan of care did not provide clear direction and that it should have been updated as a quarterly review was done in October 2014. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #32 plan of care indicates the optimal bed height is marked with red dot on the bed and on the wall.
Observations done on November 4, 6, and 12, 2014 revealed that the red dot on the wall and the bed did not match up as per plan of care.
Two of five staff interviewed were not aware that the dots were to mark the height of the bed for transfers. Registered staff indicated that the red dot was only to be on the bed and that it meant that the resident was a high risk for falls.

Staff confirmed that the red dots on the wall and bed did not match up therefore the bed was not at the safest height for resident self transfers. [s. 6. (7)]

4. The licensee failed to ensure that the resident was 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 was no longer necessary or care set out in the plan has not been effective.

A review of resident #061's clinical health record indicated that in January 2013, the home's Registered Dietitian documented that they received a referral related to altered skin integrity. Beneprotein was initiated however, there was no reassessment of the residents energy, protein, fluids and vitamin/mineral supplement.

In February 2013, the Registered Dietitian initiated resource supplement three times daily.

The home's Clinical Nutrition-Altered Skin Integrity policy V9-028, indicated that the Registered Dietitian would complete a nutritional assessment for the resident which would include an assessment of energy, protein and fluid requirements, and the need for vitamin/mineral supplements. Recommendations for this altered skin integrity recommended 30-35 calories/kilograms(kg); 1.5 grams/kg of protein, 30-35 millilitres (ml)/kg and multivitamin/mineral supplements, vitamin C and zinc.

The residents plan of care related to nutrition dated August 27, 2014, indicated that the residents fluid goal was 12 servings (1500 ml) only 21 ml/kg based on the resident's August 2014 weight. There was no other nutritional requirements and goals indicated for energy and protein.

There was no reassessment of the residents nutritional requirements and interventions to determine if the nutritional interventions initiated January and February 2013, were

effective for this resident.

The Registered Dietitian confirmed their was no reassessment in the residents clinical health record that included the residents nutritional requirements related to altered skin integrity and an evaluation of the effectiveness of interventions. [s. 6. (10) (b)]

5. The licensee has failed to ensure that if the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, have different approaches been considered in the revision of the plan of care.

Review of resident #32 record revealed that they have had falls.
Interviews with staff revealed that a clip alarm was tried in the past but was not effective.
When asked if other style alarms were tried the staff stated that they were not aware that any other styles were tried.
The Associate Director of Care confirmed that different approaches had not been considered such as a style sensor alarm but stated that it would be a good idea to try it.
[s. 6. (11) (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 there is a written plan of care for each resident that sets out the planned care for the resident, and provides clear directions to staff and others who provide direct care to the resident; that the care set out in the plan of care is provided to the resident as specified in the plan; to 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; and when a resident is reassessed and the plan of care reviewed and revised 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, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to minimize restraining of residents was complied with.

Policy number V3-1340 titled Restraint and PASD Mechanical revised April 2013 was reviewed and it states that Personal Support Workers are to monitor the resident at least every hour (1) during the time the physical device or PASD was used and document. The policy further states that for a Restraint –Release and reposition the resident at least once every two (2) hours and document.
For a PASD –Release and reposition the resident at least once every two hours, if the resident is unable to reposition self and document.

a) Record review for resident #03 indicated that a PASD was applied but it was not released and the resident was not repositioned at least once every two hours.

The Assistant Director of Care confirmed that the expectation was to monitor the resident at least every hour (1) during the time the PASD was used and release and reposition the resident at least once every two hours and document. The ADOC confirmed that this was not done and the policy was not complied with.

b) Review of the clinical record for resident #012 revealed that they had a physical restraint, seat belt related to safety.

Record review revealed that the resident was not monitored hourly and the restraint was not released and resident was not repositioned every two hours.

The Associate Director of Care confirmed that the expectation was to monitor the resident at least every hour (1) during the time the PASD was used and release and reposition the resident at least once every two hours and document. The Associate Director of Care confirmed that this was not done and the policy was not complied with.
[s. 29. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the policy to minimize restraining of residents is complied with, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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. O. Reg. 79/10, s. 30 (1).
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. O. Reg. 79/10, s. 30 (1).
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. O. Reg. 79/10, s. 30 (1).
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).

Findings/Faits saillants :

1. The licensee failed to 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:
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. A written record is kept 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.

a) Review of the 2013 Quality and Risk Management Annual Report includes an evaluation of the Continence Care and Bowel Management program dated February 2014. The report does not provide the names of the persons who participated in the evaluation. The evaluation summary indicates that a bowel protocol for occasional constipation was developed and implemented by the DOC and medical director and staff were educated. The date of the implementation of these changes is documented as November 2011.

Inspector #532 interviewed the Executive Director who confirmed that the date the changes were implemented was wrongly documented and there was no date attached to the changes that were implemented. The Executive Director was not able to confirm who participated in the annual evaluation as it only indicates the leadership team.

b) Review of the 2013 Quality and Risk Management Annual Report includes an Annual Evaluation of the Skin and Wound Care Management Program. The date on the annual evaluation template is February 2014, however the brief description indicates that a focus quality improvement to decrease internally acquired pressure ulcers by 25% and all decubiti by 30% in 2013. Under the section entitled changes made to the program/policy it indicates that updates to skin and wound care policies are ongoing and that Assistant DOC is working closely with registered staff to ensure consistency within the home.

There is no written record kept that includes the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.
The Acting Director of Care confirmed that there is no annual evaluation of the skin and wound care program.

c) Review of the 2013 Quality and Risk Management Annual Report includes an evaluation of the Falls Prevention and Management program dated January 13, 2014. The evaluation does not include the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. The summary of the changes made to the program state "perform fall huddles on point click care" stating those changes were implemented in 2012.

The Associate Director of Care who is the lead of the falls prevention program was not aware of an evaluation of the program and did not recall participating in the evaluation. [s. 30. (1)]

2. The licensee has failed to ensure that actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Resident #32's plan of care states that staff are to monitor hourly for safety. There is no documentation indicating that these checks have been conducted and there is no documentation of the resident's response to this intervention.

Review of resident #32's plan of care states that staff will attempt to toilet resident every 2 hours. There is no documentation as to when the resident is being toileted and to the response of this intervention. Interview with staff confirmed that they do not know when the resident was toileted during days but indicated when they toileted the resident during their evening shifts.

The Associate Director of Care confirmed that there are no responses to the interventions documented. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the required programs under sections 8 to 16 of the Act and for each of the interdisciplinary programs required under section 48 of the regulation that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and 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, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home.

a) The Minimum Data Set (MDS) Assessment for resident #42 identified the resident as having minimal difficulty hearing when not in a quiet setting. It further indicates that resident #42 is usually understood, but does have difficulty finding words or finishing thoughts. The resident usually understands others but may miss some part or intent of a message.

Interview with the Associate Director of Care revealed that registered staff assess

residents for their communication abilities and document quarterly on the MDS Assessment. If there are communication difficulties identified on MDS it is the home's expectation that a care plan would be created. The Associate Director of Care confirmed that resident #42 has communication difficulties but there was no care plan with documented strategies and interventions to address the residents' compromised communication.

b) The Minimum Data Set (MDS) Assessment for resident #19 identified the resident as having minimal difficulty hearing when not in a quiet setting. It further indicates that resident #19 is usually understood, but does have difficulty finding words or finishing thoughts. The resident sometimes understands and responds adequately to simple direct communication.

Interview with the Associate Director of Care revealed that registered staff assess residents for their communication abilities and document quarterly on the MDS Assessment. If there are communication difficulties identified on MDS it is the home's expectation that a care plan would be created. The Associate Director of Care confirmed that resident #19 had communication difficulties as identified by the MDS assessment, but there was no care plan with documented strategies and interventions to address the residents' compromised communication skills.

c) Record review revealed that resident #33's MDS assessment indicted that they had minimal difficulty with hearing when not in a quiet setting, that their mode of expression was speech, and that they had difficulty finding words or finishing thoughts. It indicates that communication will be addressed in the care plan. Review of the care plan revealed that communication was not addressed and interview with the Associate Director of Care confirmed this and indicated that it is the homes expectation that communication be addressed in the care plan with documented strategies and interventions as per the assessment. [s. 43.]

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 strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home, to be implemented voluntarily.

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

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident was offered a minimum of three meals daily.

During dining observation on November 3, 2014 at 1144 hours it was observed that five residents remained in their room for lunch.
At 1300 hours it was observed that the five residents that were in their rooms were not offered the lunch meal or tray service.
In an interview staff reported that staff did not keep a list of residents that don't come out for meals but they communicate to each other as to who requires tray service.
It was confirmed with the dietary staff that they were not aware of trays being prepared for the five residents as it was not communicated and the five residents were not offered a lunch meal. [s. 71. (3) (a)]

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 is offered a minimum of three meals daily, to be implemented voluntarily.

WN #11: 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:
6. Food and fluids being served at a temperature that is both safe and palatable to the 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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service that included foods and fluids served at a temperature that was both safe and palatable to the residents.

On November 13, 2014, during the breakfast meal yogurt was sitting out on the steam table ledge. The Dietary Aide confirmed that the temperature of the yogurt taken was 19.1 degrees Celsius. The Food Service Manager reported that the yogurt should have been placed on ice/ice panels or in a thermal container for the duration of the meal.

During meal observations November 3, 12 and 13, 2014, milk was in carafes and placed on each resident table prior to the commencing of first sitting. The carafes were observed being refilled after first sitting however, the milk in the carafes for first sitting was not removed prior to refilling. Temperature of the milk taken was 10.1 degrees

Celsius. The Food Service Manager reported that the process was for staff to remove the milk that sat during first sitting prior to refilling the carafes. The Food Service Manager reported that they had tried another carafe to try and maintain cooler temperatures.

Foods and fluids were not served at a temperature that was safe and palatable. [s. 73. (1) 6.]

2. The licensee failed to ensure that the home had a dining and snack service that included proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

Resident Assessment Protocol states that resident #55 is at high nutritional risk. The plan of care stated that the resident had nutritional problems related to their diagnosis and risk for developing swallowing difficulties.
On November 13, 2014 the registered staff was observed giving a supplement to resident #55. The registered staff placed the glass in the resident's hands while they were lying down in bed. The bed was observed in a flat position. When questioned if the resident was safe to drink the supplement lying down, the registered staff shared that the resident was at a 30 degree angle. However, observations revealed that the resident's bed was flat with 2 pillows under the resident's head.

The inspector questioned the registered staff again with respect to safe positioning of the resident and the registered staff returned to the room and elevated the head of the bed to a safer level. [s. 73. (1) 10.]

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 had a dining and snack service that ensures that food and fluids being served are at a temperature that is both safe and palatable to the residents and that proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping
Specifically failed to comply with the following:

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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

During the period of November 3, 2014 to November 14, 2014 inspectors noted a lingering offensive odour in the short hallway.
Observation also revealed that the dirty laundry carts and garbage carts were parked in the short hallway.
A review of the complaint log revealed that on June 18, 2014 a resident had complained that the short hallway had strong feces odour mostly before supper.

The Housekeeping Manager indicated that to address the complaints of odours, staff were reminded to spray air freshener. They indicated that staff were to use Earth Tone spray to address the odours, however, when staff were questioned the two Personal Support Workers (PSW) denied using Earth Tone and stated that they were using Air Wick.
In a second interview a housekeeping staff confirmed that the smell in the hallway was present and also reported that they used Air Wick which they had purchased.
Another PSW also confirmed that the smell was always present in the short hallway and reported that they sprayed air freshener in the hallway to counteract the smell but the smell lingers and does not go away.

The Executive Director confirmed that there were no procedures developed and implemented for addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

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

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the process to report and locate residents' lost clothing and personal items was implemented.

On November 4, 2014 resident #5 shared that they had clothing go missing. One item was found after they reported the items missing but the others have not been found.

During an interview with resident #29 they shared that they had an article of clothing missing for three weeks. The item was reported missing to staff but the resident has not heard anything.

Resident #36 reported that they had a clothing item go missing. The resident indicated that their family member does the laundry so it must have gone missing from their room.

Interview with two staff revealed that when an item is reported missing staff will search the residents' room and if it is not found they will complete a form for Missing or Lost Items. This form is posted on the nursing station for other staff to see and a copy is to be sent to the laundry. There were no Missing/Lost Item forms posted at either nurses station in the Home or in the laundry room.

Policy #V8-300 Subject: Lost/Missing Clothing dated September 2012 states that the "Lost/Missing Item" form remains in the Laundry Room until the article is found and returned to the resident or returned to the Environmental Services Manager or designate for follow up if it is determined the article is not available. The Environmental Services Manager or designate will keep the Home's management team informed of lost articles that continue to remain missing in an effort to return to the applicable owner. Once the investigation is completed and the missing item is either found or it is determined it is unavailable the Director of Administration (DOA) or designate will contact the family to advise of the outcome and sign the completed form.

Interview with the designate lead for Housekeeping and Laundry indicated that forms completed for Missing/Lost Items are posted in the laundry room. The designated lead reported that she does not keep track of what items are found or remain missing and she did not have copies of completed Missing/Lost Item forms. There was no record of the missing items reported by resident #5, #29 and #36. [s. 89. (1) (a) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process to report and locate residents' lost clothing and personal items, to be implemented voluntarily.

WN #14: 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 were stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

On November 14, 2014 observation of the medication room on Trillium Way revealed that oral stock medications and TB excel disinfectant solution was stored right beside each other. Cans of Pepsi and a bottle of energy drink were also noted to be stored in the medication fridge.

The policy titled Medication Storage and Safety, number V3-1060, stated that "only medication supplies and equipment needed for administration of medication is to be kept in the medication refrigerator."

The Acting Director of Care confirmed that the disinfectant bottles should not be stored beside the medication and took the excel TB disinfectant bottles and stored them in the cupboard under the sink. She further stated that only medication and equipment needed for administration of medication was to be stored in the medication refrigerator. [s. 129. (1) (a)]

2. The licensee failed to ensure that drugs are stored in an area or a medication cart, that is secure and locked.

On November 6, 2011 a container of hyderm cream 1 % and a container of clotimaderm cream 1% were sitting on a filing cabinet behind Trillium Way Nursing Station. The PSW at the desk confirmed that the prescription creams were not secure and locked. The PSW took the treatment creams and gave them to the registered staff to lock in the treatment cart. [s. 129. (1) (a) (ii)]

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 drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies and is secure and locked, to be implemented voluntarily.

WN #15: 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/Faits saillants :

1. The licensee failed to ensure all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On November 13, 2014 observation of Oxygen/First aid room revealed the following: The treatment cart was left open and accessible with key attached to the lock and prescription creams sitting on top of the treatment cart in two separate baskets.

The Registered Practical Nurse reported that they did not administer the treatment creams and that it was the Registered Nurses' responsibility to administer the treatments. The First Aid room was left without locking the cart or taking the keys out.

The Acting Director of Care was notified and confirmed that the prescription creams were supposed to be locked in the bottom drawer of the treatment cart and not left open with the key attached as the First Aid room was accessible to other staff and was not restricted to only persons who may dispense, prescribe or administer drugs in the home. [s. 130. 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to ensure the security of the drug supply including all areas where drugs are stored shall be kept locked at all times, when not in use and access to these areas shall be restricted to, persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must 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).

Findings/Faits saillants :

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

The following was observed on November 14, 2014 during a medication pass:

A registered staff was observed giving eye drops to resident #051 without washing their hands before and/or after the procedure.

The same registered staff was observed returning to the medication cart and taking a narcotic medication (pill) out of the blister package, placing it in their hand for a resident then crushing it and mixing it in applesauce and administering to the resident. The

resident had a contact precaution sign on the door and the staff member was observed administering the medication to the resident and coming out without washing their hands and continuing with the med pass.

The registered staff was observed monitoring blood glucose level for resident #52. Shortly after they walked over to resident #53 with the same glucometer and checked the blood glucose level. The staff member was not observed disinfecting the glucometer and or performing hand hygiene before or after the procedure between the resident.

When the registered staff was questioned concerning hand hygiene they confirmed that they did not have any hand sanitizer on their cart and were not washing their hands between residents. Once questioned the registered staff took the hand sanitizer from the medication room and placed it on their cart.

The Acting Director of Care confirmed that the expectation was for the staff member to follow routine infection control practices during the medication pass. [s. 229. (4)]

2. The licensee has failed to ensure that residents offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Resident #43 was admitted to the home and consent was obtained for the pneumovax vaccine. As of November 14, 2014 resident #43 had not received this vaccine.

Resident #42 was admitted to the home and consent was obtained for the pneumovax, tetanus and diphtheria vaccines. As of November 14, 2014 resident #42 had not received these vaccines.

Registered staff confirmed that resident #43 and #42 had not been offered immunizations against pneumococcus, tetanus and diphtheria. [s. 229. (10) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program and that residents are offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website, to be implemented voluntarily.

WN #17: 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 failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

On November 14, 2014 observations revealed the following:
a) An identified room had baseboards coming off the wall in bathroom and in room. Wall damage was noted behind the toilet and a small hole was observed in the bathroom wall. Caulking around the sink was chipped and it was brown in colour. Counter top was worn looking and wood was exposed.
b) An identified room had paint chipped off the wall behind the bed.
c) An identified room had caulking at base of toilet that was worn off and brown in colour.
d) An identified room had paint chipped off around the sink.
e) An identified room had paint chipped off the counter in the bathroom, grout was cracked and brown in colour around the sink.
f) An identified room had caulking around the sink that was brown in colour.
g) Common areas and main lounge--the legs of the furniture were worn and scratched; fabric on the arms of the easy chairs was worn through.

Maintenance staff confirmed the above observations during tour of the home on November 14, 2014 and reported that furnishings were not in good repair. [s. 15. (2) (c)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature in the home is maintained at a minimum of 22 degrees Celsius.

On November 3, 2014 during an interview with resident #11 they shared that their room was too cold and the heat should be on.

On November 3, 2014 resident #5 indicated that their room was cold.

On November 10, 2014 resident #11 was observed sitting in their room with two blankets over their legs. The resident reported that they were cold and the heat wasn't on. The temperature in resident #11's room near their bed was measured at 17 degrees Celsius and the baseboard heater under the window near resident #11's bed was cool to touch. The thermostat in the room near the door to the hall was reading 22 degrees Celsius.

On November 10, 2014 the temperature in resident #5's room near their bed was measured at 21 degrees Celsius. The thermostat positioned on the inside wall next to the hall indicated that the room temperature was set at 22 degrees Celsius.

The maintenance man confirmed that the temperature in resident #11 and #5's room was below 22 degrees Celsius. [s. 21.]

WN #19: 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. (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); 2007, c. 8, s. 85. (4).
(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; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(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 has failed to ensure that the results of the satisfaction survey are documented and made available to Residents' Council in order to seek the advice of the Council about the survey.

Interview with the Residents' Council Chair revealed that the results of the annual satisfaction survey have not been shared with the Residents' Council. The Residents' Council Chair recalls the Executive Director attending one of their meetings to review the process for the survey and to ask for input, but the Residents' Council was never provided with the results of the survey.

There was no documentation in the minutes of meetings for Residents' Council from April 2013 through September 2014 to indicate that results of the annual satisfaction survey were made available to the Residents' Council. The staff liaison to the Residents' Council confirmed that the results of the satisfaction survey were not made available to the Residents' Council. [s. 85. (4) (a)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (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 were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to ensure that the monthly analysis of all restraining of residents by use of a physical device are considered in the annual evaluation results.

In review of Fall Prevention and Restraint meeting minutes dated January 09, 2014 and February 13, 2014 it indicated that there were three residents in the home with restraints and it indicated that the number of restraints was to remain in place due to safety of residents.

Review of the annual evaluation dated February 2014 revealed that the monthly analysis of residents that were restrained was not reviewed or documented at the annual evaluation.
The Executive Director confirmed that they had completed the annual evaluation with the leadership team, however, the monthly analysis of all restraining of residents by use of a physical device was not considered in the annual evaluation results. [s. 113. (c)]

WN #21: 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/Faits saillants :

1. The licensee failed to 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.

Observations of the storage room on November 13, 2014 revealed the following:
-9 boxes (24 suppositories per box) of Glycerine Suppositories
-6 boxes (100 suppositories per box) of Dulcolax suppositories
-2000 Senokot tablets
-29 bottles of Iodine

The registered staff confirmed that this was more than a three-month supply based on resident usage. [s. 124.]

Issued on this 14th day of January, 2015

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

SHARON PERRY

Original report signed by the inspector.

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) :	SHARON PERRY (155), DOROTHY GINTHER (568), NUZHAT UDDIN (532), TAMMY SZYMANOWSKI (165)
Inspection No. / No de l'inspection :	2014_171155_0027
Log No. / Registre no:	T-000056-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 2, 2015
Licensee / Titulaire de permis :	2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP 302 Town Centre Blvd., Suite #200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	LEISUREWORLD CAREGIVING CENTRE - CREEDAN VALLEY 143 MARY STREET, CREEMORE, ON, L0M-1G0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PAULA RENTNER

To 2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8,
s. 11. (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and
(b) an organized program of hydration for the home to meet the hydration needs of residents. 2007, c. 8, s. 11. (1).

Order / Ordre :

The licensee shall ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

Grounds / Motifs :

1. During the inspection, nine residents interviewed reported that they have to wait for meals and that meal service was frequently late for second sitting. Residents and staff interviewed identified that meal service did not occur on time on a regular basis resulting in extended meal service for first and second sitting.

On November 3, 2014, lunch meal service was observed by inspectors #155 and #532 to be extended. At 1324 hours the second sitting had not commenced and a resident was observed banging the table asking for a meal. One resident stated "I am just looking for something to eat". The last entrée was served to a resident at 1345 hours, 45 minutes after the scheduled meal time and desserts had not yet been served at this time.
On November 3, 2014, a bingo activity was scheduled in the dining room for 1400 hours however, residents were still eating in the dining room and the activity was relocated to the front lounge.

Residents confirmed that activities were affected as a result of extended meal services and one resident reported that they missed scheduled activities

because they were still in the dining room eating.
One resident reported that residents on the second sitting for meals have waited twenty minutes past the scheduled meal time before being portered into the dining room as the first sitting was not on time and it was often forty-five minutes passed the commenced meal time by the time entrees were served.

One resident reported that they wait 30 minutes or longer for meals and it was often dependent on the staffing for the day.
Residents reported that the extended meal service did not provide enough time between meals and nourishment times. On November 13, 2014 the last residents on second sitting were observed finishing in the dining room at 1005 hours. At 1025 hours Personal Support Workers started passing the nourishments to residents that are on second sitting. A resident and Personal Support Workers confirmed that the nourishment time was too close to the finishing of meal times.

Several residents interviewed reported that they feel rushed and hurried during meal service. One resident reported that they felt rushed and staff take the milk and water off the table before being finished.
One resident reported that they feel rushed, staff clear the table before being finished and if they look away for a minute their coffee and milk are gone even if they were not finished.

Six of eight residents interviewed reported that they feel rushed during their meals and staff often clear tables prior to finishing their meals. It was reported that extended meal service and residents feeling rushed was raised at the last Residents Council meeting.

On November 13, 2014, staff were observed clearing and wiping tables with residents still eating. At 0954 hours three residents were sitting at an identified table, one resident finishing their drinks and one resident finishing their breakfast meal when a Personal Support Worker cleared and wiped the table with the three residents sitting at the table. A review of dietary minutes dated July 29, 2014, indicated that tables were being reset for second sitting when residents were still eating at the table.

The Food Service Manager confirmed that the timing of meal service was extended and that concerns have been raised related to residents being rushed during meal service. (165)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 23, 2015

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 :

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 to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.
The licensee shall ensure that the home's policy #V3-239 Continence Management Program is complied with--quarterly continence assessments completed for resident #43 and any other resident when there is is a change in their continence.
The licensee shall ensure that the home's policy #V3-450 Diabetes Management-Blood Glucose Monitoring is complied with.
The licensee shall ensure that the home's policy #V3-920 Medication Management Controlled and Narcotic Medication is complied with.

Grounds / Motifs :

1. The Homes Policy #V3-239 for Continence Management Program - Bladder and Bowel outlines the purpose of the program as being to ensure that the continence needs of residents are met and evaluated within 7 days of admission, quarterly and with any change in condition that affects continence.

Resident #43's admission Minimum Data Set (MDS) assessment indicates that the resident was continent of both bowel and bladder. The quarterly MDS indicates that the residents' continence had declined such that they were now usually incontinent for both bowel and bladder, with incontinent episodes once a

week or less.

There was no quarterly continence assessment found during a review of resident #43's clinical record. The Associate Director of Care confirmed that a quarterly continence assessment should have been completed for resident #43.

2. The Homes' Policy #V3-450 called Diabetes Management-Blood Glucose Monitoring, revised April 2013 states "individual glucometers are to be provided for each resident requiring regular blood glucose monitoring".

On November 13, 2014 during observation of a medication pass the following was noted:
Resident #52 was to have their blood glucose level monitored at noon. The registered staff took a glucometer out of the medication cart, checked the resident's blood glucose level and shared the results of the test with the resident. The registered staff continued with administering oral medications to resident #52. The registered staff member was not observed cleaning or disinfecting the glucometer before or after nor did they wash their hands or use gloves as instructed in the policy.

Resident #53 also required regular blood glucose monitoring and the same registered staff was observed using the same glucometer that they had used for resident #52. The registered staff was not observed cleaning or disinfecting the glucometer before or after or washing their hands, and was not observed using gloves.

When the registered staff was asked about the practice of using the same glucometer between two different residents, they confirmed that was their mistake, however, they further indicated that they wished that there was one glucometer for all the residents as it would make it easier.

The Acting Director of Care confirmed that this was not the practice of the home and all residents requiring regular blood glucose monitoring were provided with their own individual glucometers. Residents requiring regular blood glucose monitoring were noted to have their own labelled glucometers on the medication cart. She further confirmed that individual monitors were kept in the mediction cart and the expectation was that the registered staff used those assigned monitors to check the blood glucose level .

3. Policy number V3-920 titled Medication Management Controlled and Narcotic Medication, revised April 2013, states under Administration: that "the nurse is to complete the documentation on the controlled and narcotic records at the time the medication is removed from the container".

The following was observed during a medication pass on November 13, 2014: A registered staff was observed removing a pill from the blister package and placing it in their hand for resident #61 and administering the medication to the resident. No count was done at the time the medication was removed from the blister package.

The registered staff was observed to take a pill from the blister package and place in in their hand for resident #27 and then administered the medication to the resident. No count was done at the time the medication was removed from the blister package.

The registered staff was further observed taking narcotics out of the blister packages for resident #23, #25, #26, and #51 and placed them in their hand and then administered them to the residents. No count was done at the time the medication was removed from the blister packages.

When the registered staff was asked about the practice of not counting the narcotics at the time the medication was removed, the registered staff shared that they prefer to leave it until the end of the medication pass because the count won't change for the resident. In addition they indicated there was no space on the cart to keep the binder and therefore, they were not able to complete the count.

The Acting Director of Care confirmed that this was not the practice of the home and the expectation was to complete the controlled and narcotic medication count at the time of administration and confirmed that the registered staff was not complying with the Home's policy and procedures. (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 26, 2015

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the following requirements are met with respect to the restraining of resident #12, resident #14, and any other resident by a physical device under section 31 or section 36 of the Act:
s.110. (1) 1. Staff apply the physical device in accordance with any manufacturer's instructions.

Grounds / Motifs :

1. Instructions provided by Shoppers Home Health Care for the application of the two types of seat belts being used in the home indicates that in order to be effective, any belt must be positioned across the hips, not across the abdomen and it should not be too loose to allow the client to slide under the belt or too tight to irritate bony prominences or soft tissue. They indicate that the space should be just enough for two fingers to fit between the seat belt and the pelvic crest. The home's policy for Mechanical Restraint and PASD, V3-1340, states that the Personal Support Worker will ensure that the resident is seated properly in the chair and any seat belt used is space no more or less than 2 finger widths away from the residents' body.

On November 7, 2014 resident #12 was observed sitting in their wheelchair. The resident had a seat belt that was twisted and positioned loosely across the hips. The inspector found that there was enough space for the entire hand to fit between the belt and the pelvic crest.

A Personal Support Worker confirmed that the seat belt was twisted and positioned loosely on the resident. The PSW then unbuckled the belt, untwisted and tightened the belt.

On November 10, 2014 resident #12 was noted to have their seat belt on, however it was twisted and was positioned loosely. There was enough space for the entire hand to fit between the belt and the pelvic crest. The PSW reported that the seat belt was twisted under the resident but was unsure how tight the belt should be. The staff member was observed untwisting the belt and reapplying it loosely.
The Registered Practical Nurse confirmed that the seat belt was not applied correctly. The RPN took the belt off and tightened it . They confirmed that it was not applied in accordance with the manufacturer's instructions or the policy of the home.
(532)

2. On November 10, 2014 resident #14 was observed sitting in their wheelchair. The resident had a seat belt applied across the hips but it appeared to be quite loose. This inspector found that there was more than a four finger width between the belt and the residents' body. A staff member confirmed that the belt was too loose and adjusted the seat belt immediately.

On November 12, 2014 resident #14 was observed sitting in their wheelchair at the side of the bed. The resident had a seat belt applied across their hips. The inspector found that the space between the residents' body and the belt was greater than 3 finger widths. A staff member confirmed that the seat belt was too loose.

Resident #14's seat belt was not being applied in accordance with manufacturer's instructions. (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 26, 2015

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that drugs are administered to resident #32, #51 and any other residents in accordance with the directions for use specified by the prescriber.

Grounds / Motifs :

1. On November 13, 2014 during a medication pass the following was observed:

a) Resident #32 had a physician's order for a medication to be given at meal times.

The registered staff did not offer the medication and shared that they won't bother giving the medication as the resident refuses.

Record review for November 13, 2014 revealed that the registered staff documented the medication was refused by the resident, even though it was not offered to them. This was confirmed by the registered staff.

b) Resident #51 had a physician's order for a medication at meal time. The registered staff was observed offering and administering other medications to the resident but did not offer an identified medication to the resident at meal time.

Record review for November 13, 2014 revealed that the registered staff documented the identified medication was refused by the resident, even though it was not offered to the resident in accordance with the directions for use specified by the prescriber. (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 26, 2015

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Order / Ordre :

The licensee shall ensure that where a resident is being restrained by a physical device under section 31 of the Act:
That resident #14 and any other resident restrained by a physical device is released from the physical device and repositioned at least once every two hours.

Grounds / Motifs :

1. Clinical record review revealed that resident #14 has a physical restraint in the form of a seat belt for safety. The seat belt will be on at all times when the resident is up in the wheelchair. Safety checks will occur hourly while wearing the seat belt and the resident will be repositioned every two hours.

Resident #14 was observed sitting up in their wheelchair on November 13, 2014 between 09:30 and 13:30 hours. The resident had a seat belt applied across the hip region. Staff were observed on two occasions to visually check the resident but the physical device was not released and the resident was not repositioned.

Staff interview confirmed that the resident was visually checked to ensure the seat belt was applied but the physical device was not released and the resident was not repositioned. (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 26, 2015

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Order # / Ordre no : 006 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Order / Ordre :

The licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

Grounds / Motifs :

1. On November 5, 2014 during interviews with 3 PSWs they expressed that they have been instructed by the registered staff and the Director of Care that they are to administer medications to residents if the home is in outbreak and the resident is on isolation. They stated that this included pills and liquid medications. The October 2014 PSW meeting minutes state that a nurse can delegate a PSW to give a pill--if the PSW is already gowned and gloved in the room. You are not legally responsible for that situation--the nursing holds the license. How can a nurse glove, gown and mask all the time as they give meds. PSW's can offer help, especially if they are already gloved and gowned.

The Executive Director confirmed that wrong direction was given to the PSW staff by the Director of Care and that non registered staff should not be administering medications. (155)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 05, 2015

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
a)the staff member has been trained by a member of the registered nursing staff in the administration of topicals;
b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and
c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff.

Grounds / Motifs :

1. Interview with 3 PSW staff confirmed that they administer topical medications to residents and have not received any training regarding the administration of topicals. The Executive Director confirmed that the home had not provided any education to the PSWs regarding the administration of topicals. The Executive Director agreed that education needed to be provided to the PSWs before they administer anymore topical medications and that they would not be applying them until they have had education. (155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 26, 2015

Order # / Ordre no : 008 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Order / Ordre :

The licensee shall ensure that residents #54,#44 and #15 do not administer a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

Grounds / Motifs :

1. a) On November 13, 2014 a Registered Practical Nurse reported that resident #54 self administered medication.

Clinical record review revealed that there was no order from the physician for the self-administration.

b) On November 3, 2014 during lunch meal in the dining room it was observed that resident #44 had medication in a plastic medication cup and three other residents were sitting at the same table.

On November 3, 2014 the lunch meal resident #15 had medications in a plastic medication cup and three other residents were sitting at the same table.

Both residents were observed self-administering their medication. The registered staff was not monitoring the administration of the medications. Record review revealed that there were no self administration orders for resident #44 and resident #15.

c) Personal Support Worker meeting minutes from October 20, 2014 revealed that staff felt that medications were being handed over to the resident and not watched and the same thing occurred with supplements.

The Acting Director of Care confirmed no residents in the home were to self administer a drug to himself or herself unless the administration was approved by the physician. (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 26, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
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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 January, 2015

Signature of Inspector / Signature de l'inspecteur : SHARON PERRY

Name of Inspector / Nom de l'inspecteur : SHARON PERRY

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