Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

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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 |
|---|---|---|---|
| Nov 6, 2014 | 2014_321501_0015 | T-000134-14 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

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

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

LEISUREWORLD CAREGIVING CENTRE - ELLESMERE
1000 Ellesmere Road SCARBOROUGH ON M1P 5G2

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

SUSAN SEMEREDY (501), JULIENNE NGONLOGA (502), MARIA FRANCIS-ALLEN (552), PATRICIA BELL (571), TILDA HUI (512)

**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): August 25, 26, 27, 28, 29, September 2, 3, 4, 5, 8, 9 and 10, 2014.**

**This inspection was conducted concurrently with five complaint inspections (T-828 -13, 1025-14, T-462-14, T-692-14, T-335-14), four critical incidents (T-823-13, T-827-13, T-826-13 and T-840-14) and findings from these are contained in this report.**

**During the course of the inspection, the inspector(s) spoke with the executive director (ED), director of care (DOC), resident relations coordinator, program manager, environmental services manager (ESM), associate directors of care (ADOC), food services manager (FSM), food services supervisors, registered dietitian (RD), occupational therapist (OT), physiotherapist (PT), resident assessment instrument minimum data set (RAI-MDS) co-ordinator, nurse managers, registered nursing staff, personal support workers (PSWs), dietary aides, maintenance staff, housekeeping staff, residents and substitute decision makers.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**
**Accommodation Services - Laundry**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**
**Training and Orientation**

**During the course of this inspection, Non-Compliances were issued.**
**25 WN(s)**
**10 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

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

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

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

**s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).**

**s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 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).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff

who provide direct care to the resident.

Record review indicated that resident #1 was reported to have sustained bruises on his/her arm on a specified date, and on his/her leg on a specified date. A review of the resident's plan of care did not indicate any clear directions set out to address the altered skin integrities.

Interview with the PSW and registered nursing staff confirmed that they were aware of the resident's bruises, however there was no clear directions in the plan of care to address the care for the bruises. [s. 6. (1) (c)]

2. Record review revealed that resident #1 is at high nutritional risk related to dysphagia and requires a texture modified diet with additional sauces/gravy at lunch and supper meals.

On a specified date, the inspector observed resident #1 during the lunch meal to receive cream of carrot soup, minced grilled chicken burger, lettuce, tomato, and cucumber salad, without additional sauce.

Review of the kardex used by PSWs and dietary aides during meal service did not indicate to provide additional sauces/gravy at lunch and dinner for resident #1.

Interview with the FSM confirmed that this information should have been made available on the kardex for staff in the dining room in order to provide clear direction to staff providing direct care. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the resident's plan of care is based on an assessment of the resident and the resident's needs and preferences.

Interview with an identified PSW and a registered nursing staff indicated that resident #51 was continent of bladder and bowel. Staff usually leave the resident's clothes on his/her bed in the morning. The resident will partially put his/her clothes on and then wait for staff to transfer him/her to the wheelchair. The resident then goes on the toilet and cleans him/herself. The assistance that the resident needs is to transfer him/her from bed to washroom.

Record review revealed that resident was incontinent of bladder up to three to five times per week, and wearing incontinent products. There was conflicting information from the

front line staff and in the plan of care regarding the resident's continence status and the preference of the resident's daily routine regarding continence care which was not included in the plan of care. [s. 6. (2)]

4. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

On a specified date, the inspector observed resident #28 holding a positioning device in her contracted hand. Review of resident #28's plan of care revealed that a positioning device was not required.

Interview with the occupational therapist (OT) indicated that he/she had not assessed the resident or ordered a positioning device for resident #28 and the physiotherapist (PT) indicated that as long as a resident has some level of range of motion, a positioning device is not recommended. An identified registered nursing staff confirmed that a referral for the assessment of the positioning device was not made to the PT or OT.

Interview with an identified PSW indicated that sometimes he/she has placed the positioning device in the resident's hand to help release pressure from the contracted hand.

Interview with the RAI-coordinator indicated that when a PSW initiates a care such as a positioning device in the resident's hand, they should report that to the registered nursing staff and the information should be added to the resident's plan of care.

Staff involved in the different aspects of care did not collaborate with each other in the assessment of the resident. [s. 6. (4) (a)]

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

On a specified date, the inspector observed resident #30 being served mashed potatoes with his/her lunch and pushing his/her plate away. Record review of the menu revealed that whole wheat bread was to be served with this entrée, however, according to an identified dietary aide and PSW, this resident does not like bread. Review of the dietary kardex revealed that resident #30 is to be served one cup of plain rice at lunch with no mention that the resident does not like bread.

Interview with the FSM confirmed rice should have been available as an alternative to bread instead of mashed potatoes and served to this resident as specified in the plan of care. [s. 6. (7)]

6. On a specified date, resident #37 was observed during the lunch meal being served on a regular china plate that does not have a rimmed edge.

Review of the resident's plan of care indicated that the resident requires a rimmed plate as a feeding aide.

Interview with a dietary aide confirmed that the resident was not served lunch on a rimmed plate as specified in the plan of care. [s. 6. (7)]

7. The licensee failed to ensure that staff and others who provide direct care to a resident, are kept aware of the contents of the plan of care and have convenient and immediate access to it.

Record review indicated that the plans of care in resident #3 and #28's chart were last updated January 30, 2013.

Interviews with identified PSWs indicated that they are kept aware of the content of the resident's plan of care by referring to the detailed plan of care which is available in the resident's chart and also partially in point of care (POC).

Interview with the ADOC indicated that PSWs refer to the plan of care in the resident chart and POC to provide care, and confirmed that for residents #3 and #28 the plan of care in the chart was not up to date. [s. 6. (8)]

8. Record review indicated that a hard copy of the plan of care for resident #1 was noted in the resident's chart. The print date of the copy was on January 27, 2013.

Information on the interventions to address resident #1's bruises on the arm and leg was missing from the current copy kept at the nursing station dated January 27, 2013, which PSWs refer to. [s. 6. (8)]

9. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at times when the resident's care needs change.

Record review indicated that resident #52 was described to be continent of bladder and bowel in a specific month in 2013 and started becoming incontinent as of a specified month in 2014. A continence assessment using a clinically appropriate tool was not evident at the time of change in the resident's continence care needs. An annual continence assessment was conducted on a specified date, at which time the resident was described as incontinent for both bladder and bowel.

Interview with an identified PSW confirmed that the resident's continence care needs had changed and an identified registered nursing staff confirmed that a continence assessment was not conducted at the time of the change. [s. 6. (10) (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 plan of care sets out clear directions to staff who provide direct care to the resident, that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, that the care set out in the plan of care is provided to the resident as specified in the plan, that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and have convenient and immediate access to it and that the resident is reassessed and the plan of care reviewed and revised at times when the resident's care needs change, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home**

**Specifically failed to comply with the following:**

**s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:**
**2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

On August 25, 2014, the inspector observed the door to the receiving area was not secure as it was easily pushed open and there were no staff present. This door was in a service area of the home which was accessible to residents. The receiving area had a garage door that could be opened from the inside. Interview with the ESM indicated and demonstrated that cardboard boxes that had been broken down and propped against the wall beside the door, had stopped the receiving door from closing completely. [s. 9. (1) 2.]

2. On the same day, the inspector observed in the same service area, two doors leading to the kitchen to be unlocked and a middle door to be propped open. Staff were observed in the area where the west kitchen door was unlocked but no staff were observed in the dish washing area where the middle door was propped open.

The unlocked east kitchen door lead to an area that contained an open servery and a housekeeping closet. The servery contained appliances that were turned off. The housekeeping closet contained hazardous materials. As well, two puddles of water were observed on the floor with no wet floor signs.

In an interview with the ESM and FSM on August 25, 2014, it was demonstrated that the east kitchen door was unlocked and the housekeeping closet open. The ESM closed the door to the housekeeping closet and the FSM locked the east door and the door to the dish washing area.

On August 26, 2014, the inspector observed all three kitchen doors to be unlocked. The ESM and the Dietary Manager were informed.

Interview with the ESM and administrator confirmed that the hallway where the receiving door and kitchen doors were located was not secure which made these non-residential areas accessible to residents. This hallway was observed locked on September 2, 2014, and for all subsequent days that the inspectors were in the home. [s. 9. (1) 2.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors in the service area are inaccessible to residents by keeping this service area locked, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails**

**Specifically failed to comply with the following:**

**s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,**
**(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).**
**(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).**
**(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that where bed rails are used, the resident's bed system has been evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Record review of the home's bed system evaluation by Cardinal Health in August 2013, indicated that resident #12's bed system was assessed for full size rails. Resident #12's current bed system has two quarter bed rails. Interview with the ADOC and ESM revealed that the full side bed rails were replaced by two quarter bed rails after the evaluation in August 2013 and the new bed system has not been evaluated. [s. 15. (1) (a)]

2. Record review of the home's bed system evaluation by Cardinal Health in August 2013 and interview with the ADOC and physiotherapist confirmed that resident #3 had not been assessed for the use of bed rails, and his/her bed system had not been evaluated. [s. 15. (1) (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 where bed rails are used, the resident's bed system has been evaluated and that when the home changes a resident's bed system that it is re-evaluated, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that their resident-staff communication and response system allows calls to be cancelled only at the point of activation.

Review of the home's policy #V3-250 titled Call Bell System revised March 2012, indicated that the call bell system will provide for visual and audio identification of the source of the call bell, which can only be terminated at the source of call.

On August 26, 2014, the inspector observed that a call bell that was being tested was inaudible but the light had come on in the hallway. Interviews with the ESM indicated that call bells can be silenced at the nursing station and alarms can be silenced by staff, residents or visitors for approximately 2 minutes from panels in the hallways. The ESM also indicated that staff are provided ongoing education on the importance of not silencing alarms.

On August 28, 2014, a maintenance worker demonstrated to the inspector the call bell system on the second floor. Several call bells were able to be silenced at the console at the nursing station indefinitely until a button on the console was depressed again. When this was done the bells did not sound again but a new bell activated triggered the audio. When a button was depressed on the console in the hallway, the alarm was silenced in that hallway for several minutes.

The home made the consoles in the hallway inaccessible by placing plastic boxes with locks over them on September 2, 2014 but the communication response system could still be silenced at the nursing station. [s. 17. (1) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that activated resident-staff communication and response system is not silenced or deactivated from the nursing station or hallway consoles., to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that residents are protected from abuse by anyone.

Record review indicated that on a specified date, at a specified time, in the TV room on an identified floor, resident #15 was observed by a PSW being touched by resident #59. Resident #59 had ambulated with walker, approached the resident from behind and touched him/her. The resident held the resident #59's hand trying to remove it. These residents were immediately separated by the home's staff. Resident #59 had a history of aggression towards other residents, staff and family members, had conflicts with every roommate he/she shared rooms with and finally was given preferred private accommodation. He/she also had a separate table in the dining room due to conflicts with his/her tablemates. There was an existing contract between the resident and the home management that specifically addressed resident #59's behaviour and was reviewed after every incident. Resident #59 was arrested by police and taken to the local police division after this incident.

Interviews with the nursing staff on the floor confirmed that this abuse had occurred. [s. 19. (1)]

2. The licensee has failed to ensure that residents are protected from neglect by the staff in the home.

Record review indicated that on a specified date, at a specified time, resident #52 was visited by a family member, found the resident to be wet, and asked the assigned PSW to change the resident. The PSW said that she would do it later. The family member left and after returning four hours later, found the resident had not been changed and was still wet. The family member felt that the resident was neglected and reported the incident to the home's management. The home conducted a full investigation with the involved staff and a care conference with the resident's family members and the resident was held within 24 hours.

Interview with the administrator confirmed that neglect by the involved staff in the home had occurred. The staff was found negligent and had also conducted themselves inappropriately by getting into an argument with the family at the time of the incident. Disciplinary action was taken against the involved staff who was required to be retrained in Residents' Bill of Rights and prevention of abuse and neglect. The involved staff was transferred to another assignment and was no longer providing care to the resident. The resident's family was satisfied with the result of the investigation and follow-up actions. [s. 19. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone and neglect by the the staff in the home, to be implemented voluntarily.***

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**WN #6: 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 failed to ensure that the home's written policy to minimize the restraining of residents
is complied with.

The home's policy titled Restraint and PASD Mechanical revised April 2013, indicated that registered
nursing staff will ensure the reassessment of the resident and evaluation of effectiveness of the
restraint or PASD is completed and signed every eight hours on the record used for documentation,
and at any other time when necessary based on the resident's condition or circumstances.

Record review and staff interview including the ADOC indicated that resident #3 is not consistently reassessed every eight hours and the home did not provide any documentation to indicate that the evaluation of effectiveness of the PASD is completed and 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 residents are reassessed every eight hours and documentation completed to indicate that the evaluation of the effectiveness of the restraint and/or PASD is completed and complied with as per the home's written policy to minimize the restraining of residents, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

**Specifically failed to comply with the following:**

**s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all staff received retraining annually relating to Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protections.

Record review revealed that not all staff received annual retraining in the above mentioned areas. Interview with the RAI-MDS Coordinator confirmed that 26 per cent of staff in 2013 did not receive this retraining. [s. 76. (4)]

2. Staff interviews revealed that they were unable to explain what whistle-blowing protection was in terms of those who make a report to the Director in terms of abuse. Review of the Nursing Quality of Care package for 2014 revealed that some of the staff members are not trained and knowledgeable about whistle-blowing protection. Review of the home's Whistle Blower Fact Sheet provided for annual training and the Whistle-blower policy #V4-390 updated September 2013 and used for orientation training, includes issues of fraud and financial malpractice with no mention of making reports to the Director as specified in the LTCHA, 2007. Interview with the DOC confirmed that the whistle-blower policy and training need to be reviewed and possibly revised. [s. 76. (4)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all staff receive retraining annually relating to Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protections, to be implemented voluntarily.***

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**WN #8: 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. (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).**

**s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:**
**7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).**

**Findings/Faits saillants :**

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

On a specified date, at a specified time, the inspector observed resident #28 sitting in his/her wheelchair with a seat belt and remained in the same position until 12:00 p.m.

Interview with an identified PSW confirmed that she positioned the resident at 9:00 a.m. after breakfast and the resident was not able to release the seat belt.

Record review indicated that resident #28 is restrained by a seat belt.

Interviews with identified PSWs indicated and the ADOC confirmed that the resident is not consistently released from the seat belt and repositioned at least every two hours. [s. 110. (2) 4.]

2. The licensee failed to ensure that there is documentation that includes every release of the device and all repositioning.

Review of the resident #28's plan of care indicated that there is no documented evidence that the resident is released from the seat belt and repositioned.

Interview with the ADOC indicated that nursing staff failed to add the documentation to the Point of Care (POC) used by PSWs to document the release of the seat belt and repositioning of the resident. [s. 110. (7) 7.]

***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 staff release the resident from the physical device and reposition at least once every two hours and that there is documentation that includes every release of the device and all repositioning, to be implemented voluntarily.***

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

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

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

Interview with resident #56 and spouse indicated that the resident had received medications that were prescribed for his/her roommate on specified dates. The resident understands and speaks adequate English and knows his/her own medications. The resident told the spouse about the two incidents and the spouse reported them to the charge nurse. A medication incident report was filed by the charge nurse.

Interview with an identified registered nursing staff and the DOC confirmed that the resident was administered medication not prescribed for the resident. [s. 131. (1)]

2. The licensee has failed to 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.

On a specified date, resident #10 was observed with medication in his/her room. Review of clinical records indicated the resident had not been approved by a physician to self-administer medication. [s. 131. (5)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident and that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.***

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

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

On August 26, 2014, the inspector observed resident #3 to have an unlabelled wash basin and bed pan in a shared washroom. On the same day, the inspector observed resident #6 to have an unlabelled denture cup, wash basin and bed pan in a shared washroom. These items could present an infection control risk if used by another resident. [s. 229. (4)]

2. On August 26, 2014, the inspector observed unlabelled personal care items including deodorant and mouthwash in the shared bathroom of resident #15, and unlabelled toothbrushes in the shared washroom of resident #16

On August 28, 2014, the inspector observed unlabelled deodorant in the shared bathroom of resident #17, bath sponges in the tub room of the second floor and personal care items in the tub room on the second floor west wing and unlabelled bottles of mouthwash and open toilet paper stored on the back of toilet.

These items could present an infection control risk if used by another resident [s. 229. (4)]

3. On August 26 and 27, 2014, the inspector observed unlabelled used disposable razors in the third and fourth floor shower rooms.

On September 5, 2014, the inspector observed unlabelled personal items in the second floor west wing shower/tub room: two used shower sponges, one used razor and one plastic container containing a used bar of soap.

Interview with an ADOC confirmed these items should be labelled for infection prevention and control purposes. [s. 229. (4)]

4. On September 5, 2014, the inspector observed dirty landings of the sit to stand lifts in the first floor and second floor west wing shower/tub room. Interview with an ADOC and ESM confirmed that these should be cleaned after every use by the personal support workers in order to prevent infection. [s. 229. (4)]

5. On a specified date, resident #42 was observed being in contact precaution, which requires staff to wear following personal protective equipment (PPE) while providing direct care to the resident: gown, mask and gloves.

An identified PSW was observed toileting resident #42 without any PPE.
In an interview the identified PSW acknowledged being aware of the infection control precaution required to provide direct care to the resident but indicated that the PPE was no longer necessary because the resident was observed eating his/her meals in the dining room and participating in group activities.

Interview with the registered staff indicated that resident #42's health condition had not improved, that the infection control precautions remained in effect and staff should have complied with these precautions. [s. 229. (4)]

6. On a specified date, the inspector observed resident #37 in bed on his/her side for a dressing change by two identified RPNs, one of whom was a new graduate. The new graduate RPN removed the gauze dressing on resident's arm with a gloved hand and then touched the clean dressing supplies with the same gloved hand.

Interview with the RPNs confirmed that the gloves used to remove the soiled dressing should have been removed and hand hygiene performed prior to touching the clean supplies. [s. 229. (4)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.***

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**WN #11: 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:**
**11. Every resident has the right to,**
**i. participate fully in the development, implementation, review and revision of his or her plan of care,**
**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that residents' personal health information within the meaning of the Personal Health Information Protection Act, 2004 was kept confidential in accordance with that Act.

On September 2, 2014, the inspector observed resident #41's private health information displayed on the e-MAR computer screen in the hallway and staff were not present. A registered staff member was assisting a resident in the dining room. Interview with another registered staff member confirmed that resident information should be kept confidential.

On September 3, 2014, the inspector observed resident #42's private health information displayed on the e-MAR computer screen in the hallway and staff were not present. Interview with an identified registered staff member indicated that he/she opened the e-MAR to check resident information and a family member called him/her into the dining room and he/she forgot to close the computer. She also confirmed that resident information should be kept confidential. [s. 3. (1) 11. iv.]

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**WN #12: 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 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 is complied with.

Review of the home's policy #V3-1050 titled Medication Management - Resident Self Administration indicates that a resident may self-administer their medication only upon a physician's order and for the safety of others, medications must be kept in a locked container in the resident's room.

On a specified date, resident #10 was observed with three medications in his room that were located in a cardboard box on top of a desk. Record review revealed that resident #10 had not been assessed as capable to self administer medications. [s. 8. (1)]

2. The home's policy #V8-300 titled Lost/Missing Clothing revised September 2012, states 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.

Interviews with residents #5, 17, and 32 revealed that they reported missing laundry items, have not received the missing items and have not had a response from the home. Interview with ESM and ED revealed that there are gaps with the current process for lost and missing clothing and confirmed that they do not have a record of all missing items as the form is improperly used at the present time. [s. 8. (1) (b)]

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**WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home, its furnishings and equipment is kept clean and sanitary.

On September 2, 2014, the inspector observed that some contact surfaces in room #327 were dusty, grimy and dirty. There was a small personal fridge that was dirty inside and out with many dirty, broken dishes and pieces of cutlery lying on top. There was also a small corner table that was cluttered with many personal food items and toiletries which were all caked with dust. Interview with the ESM confirmed that this room had not been kept clean and sanitary.

Review of the home's policy #V6-030 titled Cleaning, Disinfection and Sanitization states that a schedule will be in place for routine weekly cleaning and disinfecting of resident mobility devices, such as wheelchairs and walkers.

On September 2, 2014, the inspector observed that resident #29's walker was very dirty and resident #28's wheelchair was dirty and in disrepair. Interview with the DOC revealed there is supposed to be a cleaning schedule for these items but that it is not being kept up to date. The DOC confirmed that these items should be kept clean and that the chair found in disrepair was an infection prevention and control issue. [s. 15. (2) (a)]

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**WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's sleep patterns and preferences for the resident.

Interview with resident #10 indicated that he/she prefers to get out of bed before 6:30 a.m. He/she indicated that some staff members working the night shift used to accommodate him/her, while others have told him/her that they are too busy to get him/her up. The resident stated that he/she informed staff on numerous occasions about his/her preference to get out of bed early, did not hear back from them and finally gave up.

Record review revealed that the resident request to get out of bed early was not documented.

Interview with an identified nursing staff member confirmed that 6-12 months ago, resident #10 informed him/her a few times that he/she wanted to get out of bed before 6:30 a.m. The staff member indicated that he/she spoke with the night shift staff who informed him/her that the resident requires two people for transfer and they are too busy to get him/her up prior to the end of their shift. The nursing staff member indicated he/she thought the resident was alright and did not look further into accommodating the resident's request because he/she did not ask her again. [s. 26. (3) 21.]

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**WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 38. Notification re personal belongings, etc.**
**Every licensee of a long-term care home shall ensure that a resident or the resident's substitute decision-maker is notified when,**
**(a) the resident's personal aids or equipment are not in good working order or require repair; or**
**(b) the resident requires new personal belongings. O. Reg. 79/10, s. 38.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the SDM is notified when the resident's personal aids or equipment are not in good working order or require repair.

Review of the home's policy #V3-1205 titled Personal Aids and Equipment – Resident revised August 2012 states that personal aids and equipment are to be checked by staff in order to maintain safety and effective operation.

On September 2, 2014, the inspector observed that a commode chair in resident #28's bathroom had duct tape on the seat and was cracked. Interview with the ESM confirmed that this was not the property of the home's and needed to be removed immediately as it was a sanitation and safety issue and suspected the family had brought this in. Interview with the DOC confirmed that the home should have checked this equipment and reported it and the home would set up a meeting with the family to discuss such issues. [s. 38. (a)]

2. On September 5, 2014, the inspector observed that in the bathroom of resident #61 there was a commode chair with a metal frame that had a rusted seat. Interview with an ADOC and ESM confirmed that this was not the property of the home's and needed to be removed immediately as it was a sanitation issue and and is not maintained in good repair. The ADOC instructed registered staff to remove it immediately, replace it with one of the home's and to contact the family. [s. 38. (a)]

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**WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
**(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
**(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
**(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
**(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin teas or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Review of the progress notes revealed that resident #1 was reported by a PSW to registered nursing staff to have a bruise on his/her arm with unknown trigger on a specified date. There was no skin and wound assessment noted on the altered skin integrity on that day or days immediately after. The resident was also reported to have bruises all over his/her leg on a specified date. There was no skin and wound assessment conducted on these bruises on the day they were identified, or days immediately after. The next skin and wound assessment was conducted on a specified date during which the leg bruises were not noted in the assessment.

Interview with registered nursing staff and ADOC indicated that weekly skin and wound assessment was supposed to be conducted on all altered skin integrities including bruises. [s. 50. (2) (b) (i)]

2. Interview with resident #5 indicated that the skin tear on the back of his/her hand was the result of hitting his/her hand against the railings when the resident was being taken

out of the shower room in his/her wheelchair on a specified date.

Record review indicated and registered nursing staff interview confirmed that there was no skin and wound assessment conducted after notation of the skin tear. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin tears has been assessed by a registered dietitian who is a member of the staff of the home, and had changes made to the plan of care related to nutrition and hydration been implemented.

Record review indicated that resident #37 had been reported to have skin tears on his/her left leg on two specified dates, and on his/her right leg on a specified date. There was no evidence of any referrals made to the RD and no report of any RD assessment being conducted on these days.

Interview with an identified RPN confirmed that there were no referrals made to RD on the dates that the resident's skin tears were noted. [s. 50. (2) (b) (iii)]

4. Interview with resident #5 indicated that the skin tear on the back of his/her hand was the result of hitting his hand against the railings when he was being taken out of the shower room in his wheelchair on a specified date.

Record review indicated and registered nursing staff interview confirmed that there was no evidence of a referral made to the RD after the notation of the skin tear. [s. 50. (2) (b) (iii)]

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**WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council**

**Specifically failed to comply with the following:**

**s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a response in writing is made within 10 days of receiving Family Council advice related to concerns or recommendations.

Review of the Family Council meeting minutes revealed that:
- In August 2014, the Family Council had a concern regarding canned fruits and processed foods and a concern form was sent to the FSM August 13, 2014 with no response being documented.
- In July 2014, the Family Council had concerns regarding staffing levels and the nursing department running out of supplies. Concern forms were documented as sent July 4, 2014 however the DOC did not complete the response portion of the form until July 31, 2014 which was more than 10 days later.
- Also in July 2014, the Family Council had a concern about the air conditioning and temperature in the home and a concern form was sent to the ESM with no response being documented.
- In June 2014, the Family Council had a concern regarding the condition of newly planted plants and a concern form was sent June 9, 2014 to the program manager. A response to this concern was not completed until June 25, 2014 which was more than 10 days later.

Interview with the Family Council president revealed that the home does not respond in writing to the council within 10 days of receiving concerns. Interview with the Resident Relations Co-ordinator confirmed that the home does not always respond within 10 days and sometimes not at all. [s. 60. (2)]

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**WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that planned menu items were available at each meal.

On August 25, 2014, the inspector observed that at the lunch meal on the fourth floor mashed potatoes were being served instead of puree bread to those residents receiving a puree textured meal. Review of the therapeutic spreadsheet revealed that puree mashed potatoes was not on the menu. Interview with an identified dietary aide revealed puree bread was not sent by the kitchen so she served mashed potatoes. Interview with the FSM revealed that mashed potatoes are made available because some residents have this preference but that puree bread should also have been available. [s. 71. (4)]

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**WN #19: 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: 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 proper techniques are used to assist residents with eating.

Review of the home's policy #V9-305 titled Mealservice-Eating Assistance protocol, revised February 2013, states that the individual providing assistance for a resident should be sitting at eye level.

On August 25, 2014, the inspector observed during the lunch meal on the fourth floor, an identified PSW was standing while assisting resident #30 to drink. Interview with the PSW revealed that he/she was aware that he/she should have been seated when assisting this resident to drink. [s. 73. (1) 10.]

**WN #20: 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. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).**

**s. 85. (4) The licensee shall ensure that,**
**(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 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 failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey.

Interview with the Resident Council President revealed that the Resident Council has not seen or been asked for their advice regarding the satisfaction survey. Interview with the program manager confirmed that the satisfaction survey has not been reviewed at meetings nor was advice of the council sought regarding the development and carrying out of the survey. [s. 85. (3)]

2. The licensee failed to document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

Interview with the program manager indicated that the satisfaction survey results were not discussed with Resident Council and that the results are not posted. [s. 85. (4) (a)]

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**WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that all hazardous substances are kept inaccessible to residents at all times.

On August 28, 2014, the inspector observed that the door to the beauty salon was open and contained a bottle of disinfectant/fungicide/viricide for the cleaning and sanitizing of combs. Staff interviews confirmed that this door should be locked in order to keep hazardous chemicals inaccessible to residents. The next day the inspector observed the beauty salon door was locked and a maintenance worker was storing all the chemicals in locked cupboards. [s. 91.]

**WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

**Specifically failed to comply with the following:**

**s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:**
**1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).**
**2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).**
**3. A response shall be made to the person who made the complaint, indicating,**
**i. what the licensee has done to resolve the complaint, or**
**ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the operation of the home is responded to within 10 days indicating what the licensee has done to resolve the complaint or that the licensee believes the complaint to be unfounded and the reasons for the belief.

Interview with resident #32 revealed that he/she reported to the home some missing personal items and has never received a response from the home. Interview with registered staff and review of the lost/missing item reports revealed these items, were reported and documented as missing on a specified date. The inspector observed that these missing item reports were still posted on the nursing station bulletin board on which staff actions were documented but the sections of the form for resolution and review by the ED was blank. Interview with the ED confirmed that he was not aware of these missing items and if he had known he would have considered this a complaint which he would have investigated and responded to. [s. 101. (1)]

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**WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions**

**Specifically failed to comply with the following:**

**s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,**
**(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).**
**(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).**
**(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that medication incidents are documented, reviewed and analyzed, corrective action is taken as necessary, and a written record is kept of everything required.

Record review indicated that there was a medication incident record involving resident #56's administration of a drug prescribed for his/her roommate on a specified date. A medication incident report was filed however there was no indication that the incident was reviewed and analyzed, as the short term/follow up and corrective action, root cause analysis findings, and the long term recommendations for quality improvement column were not completed by the DOC or delegate.

Record review indicated that the registered staff's only documented action was to inform pharmacy. Interview with registered nursing staff and the DOC confirmed that the medication incident was not reviewed and analyzed. [s. 135. (2)]

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**WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program**

**Specifically failed to comply with the following:**

**s. 216. (3) The licensee shall keep a written record relating to each evaluation under subsection (2) 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. 216 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home keeps a written record relating to each program evaluation that includes the date of the evaluation, names of the persons who participated in the evaluation, a summary of the changes made and the date that the changes were implemented.

Interview with the DOC revealed that although the home does evaluation of training programs in various quality assurance committees/meetings, there is no written record of each evaluation with the above mentioned criteria. The DOC did provide a table of evaluation for some nursing programs such as skin and wound and falls prevention but this did not include other programs such as abuse recognition and prevention and behaviour management. [s. 216. (3)]

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**WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff**

**Specifically failed to comply with the following:**

**s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:**
**2. Skin and wound care. O. Reg. 79/10, s. 221 (1).**

**s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:**
**3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all direct care staff are provided training in skin and wound care.

Record review indicated that 39 per cent of all direct care staff were not provided skin and wound care training in 2013.

Interview with PSWs, registered nursing staff and an ADOC confirmed that not all direct care staff were provided skin and wound care training in 2013. [s. 221. (1) 2.]

2. The licensee has failed to ensure that training related to continence care and bowel management has been provided to all direct care staff in 2013.

Record review indicated that 85 per cent of all direct care staff did not receive continence care and bowel management training in 2013.

Interview with identified PSWs, registered nursing staff and an ADOC confirmed that not all direct care staff were provided with training in continence care and bowel management in 2013. [s. 221. (1) 3.]

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**Issued on this 19th day of November, 2014**

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

**Original report signed by the inspector.**