



**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 prévue
le Loi de 2007 les foyers de
soins de longue durée**

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

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

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
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Bureau régional de services de
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection/ Genre d'inspection
Apr 10, 2014;	2014_260521_0002 (A2) (Appeal/Dir# DR024)	L-000928-13	Critical Incident

Licensee/Titulaire de permis

RETIREMENT HOME SPECIALISTS INCORPORATED
120 Conception Bay Highway, Suite 110, Villa Nova Plaza, Conception Bay South,
ON, A1W-3A6

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

MORRISTON PARK NURSING HOME
7363 CALFASS ROAD, R. R. #2, PUSLINCH, ON, N0B-2J0

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



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REBECCA DEWITTE (521) - (A2)(Appeal/Dir# DR024)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): 07, January 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Nurse Manager, 2 Registered Practical Nurses, 1 Housekeeper, 1 Personal Support Worker

During the course of the inspection, the inspector(s) reviewed a clinical record, schedules, homes policies and procedures

The following Inspection Protocols were used during this inspection:

Falls Prevention

Medication

Personal Support Services

Findings of Non-Compliance were found during this inspection.



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :



1. The home has been the subject of two previous Compliance Orders in the past and therefore reissued that every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

The licensee failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

32/42 (76%) Registered Nursing shifts were not covered by a Registered Nurse on the schedule in January 2014.

Additional Required Actions:

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

(A2)(Appeal/Dir# DR024)

The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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. (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 written plan of care failed to set out clear direction to nursing staff providing care to a resident.

2. The licensee failed to ensure that a resident was reassessed and the plan of care reviewed when a resident's care needs changed.

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 written plan of care set out clear direction to Nursing staff providing care, to be implemented voluntarily.



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

Specifically failed to comply with the following:

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 failed to comply with its own policy Contingency Plan - Registered Nurse 24/7 Coverage. Policy Number (no identifying number) revision date August 2011.

In November 2013 the staff failed to contact the staff on call, when a situation arose resulting in a change of health status for a Resident. The staff confirmed the staff should have contacted the On call staff as per policy.

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 Contingency Plan - Registered Nurse 24/7 August 2011 is complied with, to be implemented voluntarily.

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



Specifically failed to comply with the following:

s. 131. (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).

Findings/Faits saillants :

1. A note in a resident's progress notes state "Order received from MD to treat resident with medication. Pharmacy consulted - interaction between medication A and medication B therefore recommended to hold the medication A while on medication B."

In 2013 morning medication A was administered - confirmed by Medication Administration Record and staff.

November, 2013 mid morning Pharmacy consulted home.

November, 2013 noon hour medication B was administered - confirmed by Medication Administration Record and the staff.

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 administered to residents in accordance with the directions, to be implemented voluntarily.



WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes

Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. In 2013 a new medication was administered to a resident at noon. There was no further evidence to indicate monitoring continued. The Resident was found on the floor and was sent to a hospital.

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 when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response, to be implemented voluntarily.



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le Loi de 2007 les foyers de
soins de longue durée**

Issued on this 10 day of April 2014 (A2)(Appeal/Dir# DR024)

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



Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the Long-Term
Care Homes Act, 2007, S.O. 20

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.

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Name of Inspector (ID #) /

Nom de l'inspecteur (No) : REBECCA DEWITTE (521) - (A2)(Appeal/Dir#
DR024)

Inspection No. /

No de l'inspection : 2014_260521_0002 (A2)(Appeal/Dir# DR024)

Appeal/Dir# /

Appel/Dir#: DR024 (A2)

Log No. /

Registre no. : L-000928-13 (A2)(Appeal/Dir# DR024)

Type of Inspection /

Genre d'inspection: Critical Incident

Report Date(s) /

Date(s) du Rapport : Apr 10, 2014;(A2)(Appeal/Dir# DR024)

Licensee /

Titulaire de permis : RETIREMENT HOME SPECIALISTS
INCORPORATED
120 Conception Bay Highway, Suite 110, Villa Nova
Plaza, Conception Bay South, ON, A1W-3A6

LTC Home /

Foyer de SLD : MORRISTON PARK NURSING HOME
7363 CALFASS ROAD, R. R. #2, PUSLINCH, ON,
N0B-2J0



Order(s) of the Inspector

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Pursuant to section 153 and/or
section 154 of the Long-Term
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**Name of Administrator /
Nom de l'administratrice
ou de l'administrateur :**

KAREN BOLGER

To RETIREMENT HOME SPECIALISTS INCORPORATED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no :	Order Type / Genre d'ordre :
001	Compliance Orders, s. 153. (1) (a)
Linked to Existing Order / Lien vers ordre existant:	2012_024137_0051, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

LTCHA, 2007, c. 8, s. 8 (3) has been the subject of two previous Compliance Orders (Inspection 2012_024137_0051 WN & CO, 2011_026147_0001 WN & CO) and therefore reissued that every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.



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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.

Grounds / Motifs :

(A1)

1. The licensee failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

32 42 (76%) Registered Nursing shifts were not covered by an Registered Nurse from January 03 - 16, 2014 on the schedule. (521)

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

Jun 30, 2014(A2) (Appeal/Dir#: DR024)

REVIEW/APPEAL INFORMATION



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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



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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.

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 :

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.

Directeur
c/o 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, 11^e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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 :



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foyers de soins de longue durée, L.O.

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

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

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

Issued on this 10 day of April 2014 (A2)(Appeal/Dir# DR024)

**Signature of Inspector /
Signature de l'inspecteur :**

**Name of Inspector /
Nom de l'inspecteur :**

REBECCA DEWITTE - (A2)(Appeal/Dir# DR024)

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

London