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
Dec 9, 2014	2014_235507_0021	T-080-14	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

OAK TERRACE
291 MISSISSAGA STREET WEST ORILLIA ON L3V 3B9

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

STELLA NG (507), JOELLE TAILLEFER (211), MATTHEW CHIU (565)

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 20, 21, 24, 25, 26, 27 & 28, December 1 & 2, 2014.

The following Complaint Intakes were inspected concurrently with this Resident Quality Inspection (RQI): T- 481-14, T- 1067-14, T- 1167-14, and T- 1218-14.
The following Critical Incident Intakes were inspected concurrently with this Resident Quality Inspection (RQI): T- 309-14, T- 419-14, T- 948-14 and T- 1194-14.

During the course of the inspection, the inspector(s) spoke with regional managers (RMs), interim director of care (IDOC), program manager (PM), dietary manager (DM), environment services manager (ESM), physiotherapy resident (PTR), RAI/MDS coordinator, ward clerk, registered staff, personal support workers (PSWs), registered dietitian (RD), residents, family members of residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
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

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

15 WN(s)
6 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with 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. (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. (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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Record review revealed that an identified resident has responsive behaviours and it is not reflected in the resident's written plan of care. Interview with an identified registered staff revealed that the resident's responsive behaviours were not included in the written plan of care.

Interview with an identified regional manager (RM) confirmed that the identified resident's

written plan of care did not set out clear directions to staff and others who provided direct care for the resident. [s. 6. (1) (c)]

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

Interviews with an identified resident, registered staff and personal support workers (PSWs) revealed that the resident uses one three-quarter side rail when in bed for bed mobility and transfer. Record review revealed that the Minimum Data Set (MDS) assessment on three identified dates indicated that the resident did not use any bed rails.

Interview with the Resident Assessment Instrument/ Minimum Data Set (RAI/MDS) coordinator revealed that the assigned registered staff for the MDS assessment should assess the resident based on his/her observation and knowledge of the resident, resident record including Point of Care (POC), resident's chart, medication administration record (MAR) and treatment administration record (TAR), and in collaboration with PSWs.

Interview with an identified registered staff confirmed that the use of side rails for the identified resident was not included in the MDS assessment and it was an oversight. [s. 6. (4) (a)]

3. Record review of the MDS assessment on an identified date indicated that an identified resident did not have a pressure ulcer. The progress notes for two months for that period indicated that the resident had a stage 2 pressure ulcer.

Interviews with an identified registered staff and the RAI/MDS coordinator confirmed that the information from the progress notes was not integrated in the development of the resident's MDS assessment on the above mentioned date. [s. 6. (4) (a)]

4. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

On an identified date, interviews with an identified resident and the interim director of care (IDOC) revealed that the resident does not want to be woken up before 7 a.m. The

IDOC revised and updated the resident's written plan of care accordingly on the same day.

Interview with the resident indicated that he/she was woken up by a staff member prior to 7 a.m. the next day. Interview with the identified PSW revealed that he/she did not read the written plan of care of the resident and was not informed of the updates in relation to the resident's sleep pattern.

Interview with an identified RM confirmed that the staff should read the resident's plan of care prior to starting the morning care and the morning shift report should keep the staff informed of any changes in the resident's plan of care. [s. 6. (4) (b)]

5. Record review of the MDS assessment on an identified date indicated that an identified resident has responsive behaviours.

Record review and interviews with an identified registered staff and the RM confirmed that the resident's responsive behaviours were not integrated into the written plan of care. [s. 6. (4) (b)]

6. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at any time when the care set out in the plan is no longer necessary.

Record review of the plan of care for an identified resident revealed that the resident is able to perform bed mobility with staff supervision and to transfer and walk using a mobility aid with the supervision of one person.

Record review and interviews with an identified PSW and an identified registered staff revealed that since the resident returned to the home from hospital on an identified date, the resident's care needs changed. The nursing staff has been providing physical assistance to the resident for bed mobility, and two-person assistance for transferring. The identified registered staff confirmed that the identified resident's written plan of care was not revised when his/her care needs changed.

Record review of another identified resident's admission summary on an identified date, and the MDS assessments on four identified dates indicated that the resident's vision is adequate and he/she does not wear glasses. Review of the written plan of care indicates that the resident's visual function is moderately impaired and the resident wears glasses

when reading.

Observations and interviews with the identified resident, the identified PSWs and the identified registered staff confirmed that the resident does not wear glasses. Interview with the identified registered staff confirmed that the written plan of care should be revised because the care set out in the plan is no longer necessary. [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:
1. there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident,
2. the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other,
3. the staff and others involved in the different aspects of care of the resident collaborated with each other in the implementation of the plan of care so that the different aspect of care are integrated and are consistent with and complement each other, and
4. the plan of care is revised when the resident's care needs change, to be implemented voluntarily.

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 the skin and wound management program has a policy that is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Review of the home's policy titled "Revera Skin and Wound Care Program", index #: LTC-E-90, revised March 2014, indicated that resident/substitution decision-maker (SDM)/Family communication will be documented in the interdisciplinary progress notes which include:
• Involvement in the development and awareness of plan of care approaches related to skin/wound goals and interventions reflecting choices and preferences
• How long and how often has the resident had a skin breakdown/wound.

Review of the progress notes on an identified date, indicated that an identified resident sustained a skin tear that required treatment.

Interviews with an identified registered staff and the RM confirmed that there is no documentation in the resident's record indicating that the resident's SDM was aware of the plan of care approaches related to the above mentioned skin tear. [s. 8. (1) (a),s. 8. (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 skin and wound management program has a policy that is in compliance with and is implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

WN #3: 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 not neglected by the staff.

Review of an identified resident's MDS assessment on an identified date indicated that the resident is assessed as occasionally incontinent of bowel, and uses incontinence products. Review of the resident's written plan of care indicated that the resident requires extensive assistance with bed mobility and toileting with two staff.

Record review revealed and interview with an identified PSW confirmed that on an identified date, he/she found the resident lying in bed with a stained circle on the bed sheet around the resident's buttock. The resident told the PSW that he/she was sorry that he/she had messed him/herself six hours ago. The resident further told the PSW that he/she asked a staff to assist him/her to clean up, but the staff left and never returned. The identified PSW then cleaned the resident with another PSW, and found that dry feces were pasted to the resident's buttock. The identified PSW reported the incident to the registered staff two hours later.

Record review revealed and interview with the identified RM confirmed that the home conducted an internal investigation on the reported incident, and the police were involved. As a result, the involved PSW received a letter of disciplinary action in relation to the above mentioned incident. [s. 19. (1)]

2. Record review of an identified resident's written plan of care indicated that the resident requires total assistance for all toileting needs.

Record review revealed and interview with an identified PSW confirmed that on an identified date, he/she found the resident in bed and was soaking wet from head to toe. The resident's pillows were soaked and there was a pool of urine in the center of the bed. The identified PSW revealed that the staff on the previous shift were supposed to make rounds and change residents if needed. He/she revealed that sometimes the identified resident is found wet, but has never been so wet since the above mentioned date. The identified PSW reported the incident to the registered staff.

Record review revealed and interview with the identified RM confirmed that the home conducted an internal investigation on the reported incident, and the police were involved. As a result, the involved PSW received a letter of disciplinary action in relation to the above mentioned incident. [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 not neglected by the staff, to be implemented voluntarily.

WN #4: 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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 a resident at risk of altered skin integrity

receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

An identified resident was identified at risk for impaired skin integrity. Review of the progress notes revealed that the resident was hospitalized for 15 days. Record review revealed that the head-to-toe skin assessment was not conducted until eight days after the resident returned from hospital.

Interviews with identified registered staff confirmed that the head-to-toe skin assessment should be completed on the day when the resident returns from the hospital, not eight days later.

Another identified resident is identified at risk for impaired skin integrity. Review of the progress notes revealed that the resident was hospitalized for three days.

Record review revealed and interview with an identified registered staff confirmed that the head-to-toe skin assessment was not completed as required.

Home's policy titled, "Revera Skin & Wound Care Program", index # LTC-E-90, revised March 2014, indicates that all residents must have a head-to-toe skin assessment completed within 24 hours of returning from hospital. [s. 50. (2) (a) (ii)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received 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.

Record review revealed that an identified resident sustained a skin tear on an identified date. Record review and interviews with an identified registered staff and an identified RM indicated that the resident's skin tear was not assessed by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wound is assessed by a registered dietitian who is a member of the staff of the home, and any change made to the resident's plan of care relating to nutrition and hydration are implemented.

Record review revealed that an identified resident developed a stage 2 pressure ulcer on an identified date, and the resident had not been assessed by a registered dietitian (RD).

Interview with the RD confirmed that the resident has not been assessed related to nutrition and hydration for the stage 2 pressure ulcer.

Record review revealed that another identified resident sustained a skin tear on an identified date.

Record review and interview with the RD indicated that he/she did not receive a referral and the resident was not assessed related to nutrition and hydration. [s. 50. (2) (b) (iii)]

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:
1. a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital,
2. a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received 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, and
3.a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wound is assessed by a registered dietitian who is a member of the staff of the home, and any change made to the resident's plan of care relating to nutrition and hydration are implemented, to be implemented voluntarily.

WN #5: 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).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who receive training in relation to the home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities, receive retraining annually as required by the regulations.

Review of the home's policy titled "Resident Non-Abuse - Ontario", index #: LP-C-20-ON, revised September 2014, indicates that all staff members will receive annual training on the Resident Non Abuse Program Toolkit.

Record review revealed and interview with the ward clerk confirmed that 1.1 per cent of all staff did not receive training on the Resident Non Abuse Program Toolkit in 2013. [s. 76. (4)]

2. The licensee has failed to ensure that all staff who provide direct care to residents receive annual training in how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with the Act and Regulations, as a condition of continuing to have contact with residents.

Record review of the staff training record revealed and interviews with the ward clerk and IDOC confirmed that 8.3 per cent of all staff who provide direct care to residents did not receive training in "least restraints" in 2013. [s. 76. (7) 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:
1. all staff who receive training in relation to the home's policy to promote zero tolerance of abuse and neglect of residents prior to perform their responsibilities, receive retraining annually as required by the regulations, and
2.all staff who provide direct care to residents receive annual training in how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with the Act and Regulations, as a condition of continuing to have contact with residents, to be implemented voluntarily.

WN #6: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents receive skin and wound care training, as a condition of continuing to have contact with residents.

Record review and interview with the ward clerk confirmed that 91.22 per cent of staff who provide direct care to residents did not receive training in skin and wound care in 2013. [s. 221. (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 staff who provide direct care to residents receive skin and wound care training, as a condition of continuing to have contact with residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

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

On an identified date, the inspector observed that a television was placed on the floor beside an identified resident's desk and was slightly obstructing the passageway between the wall and the resident's bed.

Interview with the identified RM confirmed that the television placed on the floor was a fall hazard.

Three days later, the inspector observed that the television on the floor was removed.

On the above mentioned identified date, the inspector observed that the coiled electric extension cord was on the floor and partly obstructed the passage way in another identified resident's room.

Interview with the IDOC confirmed that the electric extension cord was a fall hazard for the residents and an unsafe hazard if the television's extension cord was accidentally pulled. [s. 5.]

WN #8: 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 has failed to ensure that where bed rails are used, the resident is assessed to minimize risk to the resident.

Interviews with an identified resident, registered staff and PSWs revealed that the resident uses one three-quarter side rail when in bed for bed mobility and transfer.

Record review and interview with an identified registered staff confirmed that the resident has not been assessed for using the side rail. [s. 15. (1) (a)]

2. On an identified date, the inspector observed that an identified resident was in bed and two three-quarter bed rails were used.

Record review revealed that the written plan of care does not indicate the use of any bed rail while the resident is in bed. Record review and interviews with the identified registered staff and the physiotherapy resident (PTR) confirmed that the identified resident was not assessed for the use of the bed rails. [s. 15. (1) (a)]

WN #9: 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 has failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

On an identified date, the inspector observed that the chain of the communication and response system in an identified resident's bathroom was too short to be used by the resident.

Interview with the identified staff indicated that the cord was broken and needed to be replaced. Four hours later, the inspector observed that a new cord for the communication and response system in the identified resident's bathroom was replaced. [s. 17. (1) (a)]

2. On an identified date, the inspector observed two identified residents' communication and response system not functioning. An identified staff member was notified. Six hours later, the inspector observed that one of the two identified residents' communication and response system was functioning.

Three days later, the inspector observed that the other identified resident's communication and response system was functioning. [s. 17. (1) (a)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that neglect of a resident by the staff that resulted in harm or a risk of harm to the resident has occurred or may occur immediately report the suspicion and the information upon which it is based to the Director.

Review of an identified resident's MDS assessment on an identified date indicated that the resident is assessed as occasionally incontinent of bowel, and uses incontinence products. Review of the resident's written plan of care on an identified date indicated that the resident requires extensive assistance with bed mobility and toileting with two staff.

On an identified date, the resident reported to an identified PSW an incidence of neglect when another PSW refused to provide continence care. The resident told the PSW that he/she was sorry that he/she had messed him/herself six hours ago. The identified PSW reported the incident to the registered staff an hour after receiving the report from the resident.

Record review and interview with the identified registered staff confirmed that he/she received the above mentioned report from the identified PSW on the above mentioned identified date. However, he/she did not report to the Director immediately as required by the Act. Instead, the identified registered staff reported the incident to the IDOC through email 3.5 hours later. The IDOC reported the incident to the ED the next morning and the incident was not reported to the Director until the afternoon. [s. 24. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal needs of residents.

Interview with an identified staff indicated that staff occasionally used the same hair brush for multiple residents because the home does not keep enough hair brushes in the storage room.

On an identified date, observation of two storage rooms in the home and interview with the identified RM confirmed that the hair brushes in both storage rooms were out of stock and the home should keep enough supply for the residents' needs. [s. 44.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Interviews with the IDOC and an identified registered staff indicated that the home uses a risk management assessment instrument in PointClickCare (PCC) to assess a resident after each fall.

An identified resident was at high risk for falls as per the written plan of care. Record review revealed that the resident fell on an identified date, and the post-fall assessment was not conducted.

Interview with the identified registered staff confirmed that the post-fall assessment should be conducted using the risk management assessment instrument after the resident's above mentioned fall, and it was not carried out. [s. 49. (2)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the copies of the inspection reports from the past two years for the long-term care home are posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

On an identified date, the inspector observed that the inspection reports for the past two years, except the inspection report #2013_168202_0020 dated May 7, 2013, were kept in a binder, and the binder was attached to the wall in the hallway on the first floor.

Interview with the IDOC confirmed that the above mentioned report was not posted as required. [s. 79. (3) (k)]

WN #14: 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:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

Interview with an identified resident revealed that while he/she is in bed, two three-quarter bed rails are always in the up position. On an identified date, the inspector observed that the resident was in bed with two three-quarter bed rails in the up position. Interviews with two identified PSWs confirmed that they usually put two bed rails up while the resident is in bed.

Record review of the home's policy titled "Least Restraints " index #: LTC-K-10, revised March 2013, indicates that if two bed rails longer than half rails are used, this is considered a restraint. Interviews with an identified registered staff, the identified PSWs and the PTR confirmed that the identified resident is able to get out of bed independently. The bed rails on both sides are physical devices that were restraining the resident from getting out of the bed.

Record review and interview with the identified registered staff confirmed that the staff applied the physical devices that have not been ordered or approved by a physician or registered nurse in the extended class. [s. 110. (2) 1.]

WN #15: 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 all staff participated in the implementation of the program.

On an identified date, the inspector and the identified RM observed an isolation signage posted on an identified resident's door. The isolation cart with all the personal protective equipment (PPE) was placed inside the room and an identified staff discarded the isolation gown in the garbage bag outside the resident's room.

Interview with the identified RM confirmed that the isolation cart should have been placed outside the resident's room and the identified staff should have discarded the isolation gown inside the resident's room.

Interview with an identified staff indicated that staff occasionally used the same hair brush for multiple residents because the home does not keep enough hair brush for the residents.

Interview with the identified RM confirmed that hair brush should not be shared between residents. [s. 229. (4)]

Issued on this 12th day of December, 2014

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

Original report signed by the inspector.