



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

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

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

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

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

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 23, 2015	2015_262523_0006	L-002138-15	Resident Quality Inspection

Licensee/Titulaire de permis

VIGOUR LIMITED PARTNERSHIP ON BEHALF OF VIGOUR
302 Town Centre Blvd Suite #200 MARKHAM ON L3R 0E8

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

LEISUREWORLD CAREGIVING CENTRE - OXFORD
263 WONHAM STREET SOUTH INGERSOLL ON N5C 3P6

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

ALI NASSER (523), DONNA TIERNEY (569), REBECCA DEWITTE (521), RUTH
HILDEBRAND (128)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): March 30, 31, April 1, 2, 7, 8, 9, 10 & 13, 2015

The following Critical Incidents inspections were conducted concurrently during this inspection:

Log # 002209-15 / 2628-000010-15

Log # 002838-15 / 2628-000013-15

Log # 004539-15 / 2628-000015-15

Log # 005180-15 / 2628-000016-15

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care(DOC), Assistant Director of Care (ADOC), Environmental Services Manager (ESM), Program's Director, a Registered Dietitian, a Dietary Aide, a Housekeeping Staff, a Maintenance Staff, a Cook, a Physiotherapy Assistant, 10 Personal Support Workers (PSW), six Registered Staff, Resident Council Representative, Family Council Representative, three family members and 40 residents. The inspector(s) also toured the home, observed meal service, medication pass, medication storage areas and care provided to residents, reviewed health records and plans of care for identified residents, reviewed policies and procedures of the home and observed general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:



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**Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
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
Skin and Wound Care**

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

12 WN(s)

11 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

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

8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents' right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, is fully respected and promoted.

Observations during the inspection revealed that resident's right to be treated with courtesy, respect and dignity were not fully promoted by staff.

All were confirmed by the DOC and Administrator who stated that the home's expectation is to have resident's treated with Dignity and respect. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the residents' right to be afforded privacy in treatment and in caring for his or her personal needs is fully respected and promoted.

Observation during the inspection revealed that four residents received treatment in a common area in front of other residents. This was not specified in their plan of care.

The Director of Care confirmed it was the home's expectation that all residents have the right to be afforded privacy in treatment and in caring for his or her personal needs. [s. 3. (1) 8.]



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 residents' right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity; and the residents' right to be afforded privacy in treatment and in caring for his or her personal needs is fully respected and promoted, to be implemented voluntarily.

**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6.
Plan of care**

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A record review for resident # 003 revealed that the plan of care does not set out clear direction in regards to a specific treatment.

An interview with the Registered Practical Nurse confirmed the plan of care failed to set out clear direction to staff. [s. 6. (1) (c)]



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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 set out clear directions to staff and others who provide care to the resident, 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

a) Observations during inspection revealed that the home did not comply with their policy titled Falls Prevention Program V3-630 by not completing a Post Fall Huddle Assessment.

Interview with the DOC confirmed that resident # 005 had a fall that the home has failed to do a Post Falls Huddle Assessment for this incident. (569)

b) Observations during inspection revealed that the home did not comply with their policy titled Head Injury Routine V3-680 revised March 2013 by not completing a Head Injury Routine for each unwitnessed fall for the full duration of the assessment time frame.

An interview with the ADOC confirmed it was the homes expectation that any resident who has suffered an unwitnessed fall would have the head injury routine assessment completed after each unwitnessed fall for the full duration of the assessment time frame (14.5 hours). [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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: 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 were used, each resident was assessed and his or her bed system was evaluated to minimize risk to the resident and steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Observations during the inspection revealed that two beds with bed rails up had the mattresses sliding side to side.

The Director of Care confirmed that the mattresses slid side to side. She acknowledged the potential risk to residents and indicated that her expectation was that all beds that used bed rails should be safe and not pose a potential entrapment risk. [s. 15. (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 where bed rails were used, each resident was assessed and his or her bed system was evaluated to minimize risk to the resident and steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:

- 1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).**
- 2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).**
- 3. The use of the PASD has been approved by,**
 - i. a physician,**
 - ii. a registered nurse,**
 - iii. a registered practical nurse,**
 - iv. a member of the College of Occupational Therapists of Ontario,**
 - v. a member of the College of Physiotherapists of Ontario, or**
 - vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).**
- 4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).**
- 5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).**

Findings/Faits saillants :



1. The licensee failed to ensure the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied: 1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 3. The use of the PASD has been approved by, i. a physician, ii. a registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapists of Ontario, v. a member of the College of Physiotherapists of Ontario, or vi. any other person provided for in the regulations. 4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 5. The plan of care provides for everything required under subsection (5).

A) Observations during inspection revealed that resident # 002 was using a Personal Assisted Safety Device (PASD) on a daily basis, the use of PASD was not documented in the plan of care, there was no consent for the use of PASD and the PASD had not been approved by any person provided for in the regulations.

An interview with the Director of Care confirmed it was the home's expectation that all of the above would be completed with all resident's receiving a PASD.

B) Observations and record review revealed that resident # 003 had safety equipment used with no assessment and documented approval for the use of that equipment, and no written consent for the use of the Personal Assisted Safety Device (PASD).

An interview with the Director of Care confirmed it was the home's expectation that the use of the PASD was to be assessed, approved and consented. [s. 33. (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 the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied: The use of the PASD has been approved by, i. a physician, ii. a registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapists of Ontario, v. a member of the College of Physiotherapists of Ontario, or vi. any other person provided for in the regulations. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #6: 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 tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff.

A record review for resident # 003 revealed that the care plan indicated the resident was to have weekly wound assessments. The wound assessment has not been done for six weeks.

An interview with the Registered Practical Nurse confirmed that resident # 003 had not received a weekly wound assessment. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs



Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,

(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).

(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).

(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).

(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).

(e) a weight monitoring system to measure and record with respect to each resident,

(i) weight on admission and monthly thereafter, and

(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the Nutrition Care and Hydration Program resident's height are taken upon admission and annually thereafter.

A clinical record review revealed that 5 out of 13 residents did not have their heights taken annually.

A Registered Staff member stated "we only take residents heights on admission".

In an interview the DOC confirmed expectation that resident' heights are taken upon admission and annually thereafter. [s. 68. (2) (e) (ii)]



Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that as part of the Nutrition Care and Hydration Program resident's heights are taken upon admission and annually thereafter, to be implemented voluntarily.

WN #8: 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).**

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

Findings/Faits saillants :



1. The licensee failed to ensure that proper techniques to assist residents with eating, including safe positioning of residents who required assistance were used during each dining and snack service.

Observations during inspection revealed that a Personal Support Worker was assisting resident # 034 with feeding while the Personal Support Worker was standing approximately 12 inches above eye level placing the resident at potential choking risk. Resident # 034 is at documented choking risk.

The PSW acknowledged that the expectation was that he/she should have been seated while assisting the resident.

The Director of Care indicated that all staff are expected to be seated while assisting residents to consume food and fluids. [s. 73. (1) 10.]

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

Observations during inspection revealed that resident # 005 required assistance with eating. Resident # 005 was served the breakfast meal ten minutes before the assistance arrived to help the resident with eating.

An interview with the Registered Practical Nurse confirmed the resident required assistance with eating and the resident had been served the meal before someone was available to provide the assistance.

An Interview with the Director of Care and the Administrator confirmed it was the home's expectation that residents who require assistance with eating or drinking are only served when the staff is available to provide the assistance. [s. 73. (2) (b)]



Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents who require assistance with eating or drinking only served a meal when someone is available to provide the assistance and that proper techniques to assist residents with eating, including safe positioning of residents who required assistance were used during each dining and snack service, to be implemented voluntarily.

WN #9: 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. (2) The licensee shall ensure that a documented record is kept in the home that includes,

(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record is kept in the home that includes the nature of each verbal or written complaint.

A family interview of resident # 001 revealed the family has made a verbal complaint regarding the residents care.

A record review revealed the verbal complaint had not been documented.

An interview with the Registered Practical Nurse who received the verbal complaint confirmed that the complaint was not documented.

An interview with the Director of Care confirmed it was the home's expectation that all complaints are recorded. [s. 101. (2) (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 a documented record is kept in the home that includes the nature of each verbal or written complaint, to be implemented voluntarily.

**WN #10: 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. (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:

- 1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).**
- 2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).**
- 3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).**
- 4. Consent. O. Reg. 79/10, s. 110 (7).**
- 5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).**
- 6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).**
- 7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).**
- 8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).**

Findings/Faits saillants :



1. The licensee failed to 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: 3. The person who made the order, what device was ordered, and any instructions relating to the order. 4. Consent. 5. The person who applied the device and the time of application. 6. All assessment, reassessment and monitoring, including the resident's response. 7. Every release of the device and all repositioning.

Observation during inspection revealed that resident # 001 had two restraints applied.

Review of the resident's clinical record revealed the following:

- a) There was no written order for one of the restraints.
- b) No consent for both restraints.
- c) No documentation as to who applied the restraint, the times of the application and the hourly monitoring while the resident was in the restraint.

An interview with the Director of Care confirmed it was the home's expectation that every use of a physical device to restrain a resident should be ordered, consented to, and resident monitored during the application of the restraint. [s. 110. (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 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: 3. The person who made the order, what device was ordered, and any instructions relating to the order. 4. Consent. 5. The person who applied the device and the time of application. 6. All assessment, reassessment and monitoring, including the resident's response. 7. Every release of the device and all repositioning., to be implemented voluntarily.

WN #11: 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 participate in the implementation of the infection prevention and control program.

Observation during the medication pass revealed that staff member did not implement proper infection prevention and control measures while providing a specific treatment to specific residents.

An interview with the Director of Care confirmed it was the homes expectation that the staff participate in the implementation of the infection prevention and control program. [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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :



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1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres.

Observations during the inspection revealed that some windows in certain common areas opened more than 15 centimeters.

The Director of Care acknowledged the potential risk to residents and indicated that her expectation was that the window openings should be restricted to meet legislation.

All windows were adjusted to open only 15 centimeters by the end of the inspection. [s. 16.]

Issued on this 27th day of April, 2015

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

Original report signed by the inspector.