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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 9, 2015	2014_211106_0017	S-000432-14	Resident Quality Inspection

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA
1220 Valley Drive KENORA ON P9N 2W7

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

PINECREST
1220 VALLEY DRIVE KENORA ON P9N 2W7

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

MARGOT BURNS-PROUTY (106), BEVERLEY GELLERT (597), LAUREN TENHUNEN (196)

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): October 14, 15, 16, 17, 20, 21, 22, 23, 24, 2014

The following Logs were reviewed as part of this inspection: S-000370-13, S-000417-13, S-000185-14, S-000266-14/00906-14, and S-000307-14/01748-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Human Resources (HR) Manager, Environmental Services Manager, Housekeepers, Recreation Coordinator, Adjuvant, Food Services Manager, Dietary Aides, Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Family Members, and Residents.

The inspector(s) also conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed the health care records for several residents, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
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
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Snack Observation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **20 WN(s)**
- **14 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. On October 16, 2014, at approximately 1500hrs, the call bell for "Hall BR" had been ringing in excess of 15 minutes. Inspector #106 asked the RN on duty which bathroom was ringing. The RN said that it was a washroom that was in between the unit and the dining room and said they would go and check the bell.

On October 16, 2014, at approximately 1700 hrs, Inspector #106 responded to a call bell that had been ringing in excess of 10 minutes. The resident indicated that they wanted to get up and go sit with the other residents; the inspector stated that they would see if they could find a staff member to assist them. The inspector looked down the hall and found 3 PSWs with one resident; the staff members were discussing who should go on break. The inspector informed the staff members that the resident required assistance.

The licensee failed to ensure that the residents' rights to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, were fully respected and promoted. [s. 3. (1) 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 the residents' right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, are fully respected and promoted, specifically in regards to attending call bells within an appropriate amount of time, 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).

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

Findings/Faits saillants :

1. Resident #040 was observed in their chair with restraints applied over 4 days of the inspection.

Staff members #S-100 and #S-101 confirmed that they use resident care plans located in the purple binders to provide care for residents. They confirmed that these binders contain the most up to date care plan. Shortened versions of care plans called Resident Care and Safety Routines are also in the binder and posted in the resident's rooms.

Resident Care and Safety Routine for Resident #040 dated September 24, 2014, lists specific restraints to be applied when the resident in their chair. However, there was no mention regarding one of the restraints observed to be in use.

Care Plan dated October 15, 2014, identified interventions that included specific restraints to be used when the resident is in their chair. The care plan also identified use of a physical restraint that was not observed to be in use for Resident #040, this specific restraint was to be used to ensure correct positioning of the resident.

Inspector #597 interviewed Staff members #S-101, #S-102 and #S-103. All staff verified that the resident required the restraints that the inspector observed to be used by the resident. Staff also confirmed that the use of the specific restraint used to position the resident had been discontinued.

A progress note, from Staff member #S-104, indicated that a seating assessment was completed and specific restraint used to assist with positioning was to be removed from

the resident and replaced with another restraint (that the inspector observed in use).

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. [s. 6. (1) (c)]

2. Care Plan for Resident #041, was reviewed by Inspector #597 and the following was found:
-Resident #041 has a denture and some of their own teeth
-Interventions included, monitoring oral hygiene, reporting lack of self care, assisting in performing oral care, and referring to dentist for denture labelling, evaluation and recommendations.

The resident observation and monitoring form for the month of October was reviewed by Inspector #597. Staff documented that resident resists oral care. The care plan does not contain strategies to address resident's refusal of oral care and no evidence of referral to dentist or documentation of resident / SDM refusal was found.

Care Plan for Resident #041 indicated that they had impaired hearing and the goal was to monitor and maintain the resident's hearing aid. The care plan further directed staff how to care and store the resident's hearing aid.

Inspector #597 observed Resident #041 during the course of the RQI and noted that Resident #041 did not wear hearing aids, nor were hearing aids visible in their room.

Interviews with Staff members #S-105 and #S-106 confirmed that the resident's hearing aids have been missing for several months.

Care Plan for Resident #041 indicated that staff were to ensure fingernails were cut on bath days. Inspector #597 observed resident #041 and found that their fingernails had not been cared for by staff.

Inspector #597 interviewed staff member #S-106 on October 23, 2014 who identified themself as the RPN responsible for nail care on unit. They stated that, Resident #041 refuses nail care. Staff have tried multiple interventions without success. Both the resident's toenails and fingernails were observed to be unkempt during the inspection. The resident was observed to be wearing socks as their toenails were unkept. Staff member #S-106 stated that they are afraid that resident will fall as a result. This

information is not referenced on the care plan.

The licensee has failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. During the inspection Resident #022 was observed to be ungroomed and appeared to have a skin condition. The resident was again observed accompanied by Staff member #S-107, the resident was not appropriately groomed and their skin condition did not appear as if it had been cared for.

An interview was conducted with Staff member S-108 on October 23, 2014, at 1045hrs, and it was reported that Resident #022 is totally dependent on two staff for personal hygiene and personal care. During an interview with Staff member #S-109 on October 23, 2014, at 1015hrs, they told the inspector that this resident has a skin condition and requires a topical medication and staff are to care for the resident's skin in a specific way.

The care plan for Resident #022 was reviewed, which indicated that the resident requires assistance with activities of daily living. The care plan does not make reference to the specific requirements in regards to grooming and the resident's skin condition and subsequently does not provide clear directions to staff and others who provide direct care to the resident.

The licensee has failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

4. On October 16, 2014, Resident #021 was observed by Inspector #196 to have broken teeth. The current care plan, as found in the binder at the nursing desk, was reviewed for information regarding oral and dental care. It specified the use of a medicated oral rinse to be used twice daily and to brush the resident's teeth. The "resident observation record and monitoring form" for October 1 through and including October 20, 2014, was reviewed and the oral rinse is not documented as being used during this time period. In addition, no oral care was documented as being provided to Resident #021 on October 1, 2, 3, 5, 9, 12, 2014.

The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

5. A Critical Incident Report was submitted to the Ministry of Health and Long-Term Care in the spring of 2014, it indicated that Resident #006 was sent to hospital for assessment after a fall during a specific activity. The report also indicated that staff had left the resident unattended prior to their fall.

The Care Plan document for Resident #006 was reviewed by Inspector #106 and there were interventions in place to ensure that the resident would be monitored during a specific activity. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (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 the care set out in the plan of care is provided to the resident as specified in the plan, specifically in regards to residents #006 and #021, and 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, specifically in regards to residents #040 and #041, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On October 14, 2014, during the initial tour and throughout the RQI inspection, Inspector #106 noted that the ½ wall in a specific unit between the tv lounge and the dining area had multiple scratches, gouges and white patches.

On October 14, 2014, during the initial tour and throughout the RQI inspection, Inspector #106 noted that the flooring in the home on all units around the entrances and fire doors was cracking. On a specific unit the inspector observed multiple low spots under the flooring, many were identified with tape.

On October 23, 2014, Inspector #106 interviewed the Environmental Services Manager and they reported the following:
-they are aware of the cracks in the flooring
-the low spots under the flooring on a specific is due to the concrete disintegrating and has not been replaced due to the large cost involved
-other areas of cracking in the home are being addressed as the home can afford to replace the flooring
-the home currently has the material to adhere to the ½ wall in a specific area and plan to finish the job "soon", but declined to give an actual completion date.

The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, specifically in regards to the 1/2 wall in a specific unit between the dining room and lounge and the cracked flooring throughout the home, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On October 22, 2014, Inspector #106 found that there was no call bell at the bedside for Resident #017, a bed alarm was plugged into the port that a call bell cord/button would be attached. The inspector asked the ESM how staff would access the call bell system if they were delivering care to the resident and required extra assistance.

The ESM was unsure and called Staff member #S-118 who reported that when a bed alarm is hooked up to the call bell system staff need to put a splitter with it so both the bed alarm and call bell cord can be hooked up to the call bell system at the same time. This had not been done at this time.

The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that, is available at each bed, toilet, bath and shower location used by residents. [s. 17. (1) (d)]

2. Observed the call bell in the shared washroom for Resident #040, and noted that there was no cord on the call bell beside the toilet. There was only a short chain approximately 4" long hanging from the wall from the outlet which on the wall is approximately 5' from the floor. When a resident is sitting on the toilet they would be unable to reach the short call bell chain to call for help if they required assistance.

The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that, is available at each bed, toilet, bath and shower location used by residents. [s. 17. (1) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that, is available at each bed, toilet, bath and shower location used by residents, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. A Critical Incident Report submitted to the Ministry of Health and Long-Term Care and progress notes for Resident #005 were both reviewed by inspector #106. The documentation reviewed indicated that resident #005 was found inappropriately touching Resident #013 on 3 different occasions during the 2013. A progress note dated after the second incident, indicated that the home met with Resident #005's POA and together they determined that the resident would stay in their room or at the nursing station, rather than in the common tv lounge with vulnerable residents.

After the second incident and after it was determined the resident would only be in their room or at the nursing station, Resident #005 was found in the common tv lounge inappropriately touching Resident #013. The licensee failed to protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone and that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident 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. 31 (2).

Findings/Faits saillants :

1. During the inspection, Inspector #597 observed Resident #040 to have specific restraints in place. Resident was sitting beside the nursing station in their chair. Resident Care and Safety Routine for Resident #040, found in purple Binder and in Resident's room - lists the use of specific restraints to be used when resident is in their chair. There was no mention of one of restraints observed in use.

Staff members #S-105, #S-102 and #S-103 confirmed that this resident requires the use the specific restraints restraint while they are up in their chair to ensure correct positioning.

On October 22, 2014, the paper chart for Resident #040 was reviewed and a physician's order, for a specific restraint as needed and a note to discontinue use of another restraint were found. A current physician order for two of the restraints used were not found.

The licensee has failed to ensure that a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. [s. 31. (2) 4.]

2. Resident #022 was observed during the inspection, to be in a wheelchair with specific restraints in place. The health care records for this resident were reviewed, specifically in regards to the use of both of these devices.

The current care plan included the use of these restraints for safety. The physician's

order sheet dated September 1 to November 30, 2014, did not contain a current order for the use of the specific restraints. In addition, located at bottom of the order sheet was a space to note "restraints" and it is noted as "N/A".

Specific restraints were in use on Resident #022 and there was no current order for these restraint devices.

The licensee has failed to ensure that the restraining of a resident by a physical device is included in a resident's plan of care only if all of the following are satisfied: 4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. [s. 31. (2) 4.]

3. On October 21, 2014, Resident #001 was observed in their room watching TV and looking at pictures. One of the resident's restraints was applied and another was not applied.

Inspector #106 reviewed resident #001's health care record and found:
-the care plan document had a section titled "Physical Restraints-PASD" and indicated use specific restraints
-the consent for the use of one restraint was signed by the resident's POA
- the physician's order sheet dated October 1 to December 31, 2014, did not contain a current order for the use of specific restraints. In addition, located at bottom of the order sheet was a space to note "restraints" and it was noted as "N/A".

On October 24, 2014, Inspector #106 brought this to the RN's attention and they agreed that the resident did not have a current order for the restraints.

The Licensee failed to ensure that the restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied: 4. a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. [s. 31. (2) 4.]

4. Resident #022 was observed during the inspection, to be in a wheelchair with 2 restraints applied. The health care records for this resident were reviewed, specifically in regards to the use of both of these devices.

The current care plan included the use of both restraints while in the wheelchair for safety.

The "protective devices consent form" was reviewed and it included the use of one restraint and, two bed rails as necessary and a signature from the Power of Attorney (POA).

An interview was conducted with Staff member #S-110 on October 22, 2014, and it was confirmed with the inspector that there was no consent from the POA for use of a specific restraint. The specific restraint was being used for Resident #022 without consent from the POA.

The licensee has failed to ensure that the restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied: 5. The restraining of the resident 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. [s. 31. (2) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance failed to ensure that the restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied: 4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining, specifically in regards to residents #001, #022, and #040, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. During the inspection Resident #022 was observed to be ungroomed and appeared to have a specific skin condition. The resident was then again observed during the inspection accompanied by Staff member S-107 and the resident was ungroomed and their skin condition had not been cared for.

An interview was conducted with Staff member #S-108 on October 23, 2014, at 1045hrs, and it was reported that Resident #022 is totally dependent on two staff for personal hygiene and personal care.

During an interview with Staff member #S-109 on Oct. 23, 2014, at 1015hrs, they told Inspector #196 that this resident had a specific skin condition and requires topical medication. They also reported that the resident requires specific hygiene interventions to address their skin condition.

The care plan for Resident #022 was reviewed, which indicated that the resident requires assistance with activities of daily living. The care plan does not make reference to the specific requirements in regards to grooming and the resident's skin condition and grooming. Resident #022 was not provided with individualized personal care, to meet their specific needs.

The licensee has failed to ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. [s. 32.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis, specifically in regards to resident #022, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. During the inspection Resident #020 was observed sitting in their chair in the common TV room. The resident's hair looked greasy and unkempt. The bath list as found on the nursing desk noted this resident to be scheduled to have a bath in the evening on Wednesdays and and on Saturdays.

The "Resident Observation and Monitoring Form" for the month of October 2014, was reviewed for Resident #020, in regards to documentation of personal hygiene/bathing and there were no baths documented as being provided, nor any refusals of baths recorded from October 1 through and including October 21, 2014.

The licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. [s. 33. (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 that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, specifically in regards to resident #020, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. Inspector #597 observed Resident #041 throughout the RQI and resident noted to have dental problems.

During the family interview in stage 1, the resident's substitute decision maker (SDM) indicated that the resident may be having problems with their denture.

Care Plan for Resident #041, was reviewed by Inspector #597 and the following was found:
-Resident #041 has a denture and some of their own teeth
-Interventions included, monitoring oral hygiene, reporting lack of self care, assisting in performing oral care, and referring to dentist for denture labelling, evaluation and recommendations.

Resident Care and Safety Routine document posted in resident's room states staff to provide mouth care, encourage resident to clean. Resident Observation and Monitoring Form reviewed for Resident #041 indicated, Oral Care not done due to resident REFUSAL on the following dates October 19, 20, 21, 22 and 23, 2014.

The licensee has failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, (a) mouth care in the morning and evening, including the cleaning of dentures. [s. 34. (1) (a)]

2. Inspector #597 interviewed the Director of Care (DOC), on October 23, 2014, who

confirmed that the home does not offer annual dental assessment and other preventive dental services at this time. [s. 34. (1) (c)]

3. Resident #021 was observed during the inspection to have dental problems. An interview was conducted with DOC staff member #S-111 on October 23, 2014 and it was determined that there was no evidence that residents were offered an annual dental assessment.

The licensee has failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. [s. 34. (1) (c)]

4. During the inspection Resident #023 was observed to have dental problems. The health care record for Resident #023 was reviewed for information relating to oral care. The most recent MDS assessment identified this resident as having dental problems.

An interview was conducted with DOC staff member #S-111 on October 23, 2014, and it was determined that there was no evidence that residents are offered an annual dental assessment.

The licensee has failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, (c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. [s. 34. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required, specifically in regards to residents #021, #023, #041, and #042, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. It was determined in stage one of this inspection that Resident #002 was not involved in many activities. During the course of this inspection, Inspector #106 observed a

specific unit at various times of the day and routinely found there were regularly, in excess of 10 residents in the tv lounge near the nursing station with no activity provided to them.

On October 15, 2014, the inspector observed 15 residents in the tv lounge near the nursing station, no staff were present other than 1 PSW working on the unit assisting other residents. The PSW stated that the other staff members were on lunch and would be back at 1130 hrs. Once the staff members came back from lunch the 15 residents were still congregated in the lounge with no activity other than the tv but, few residents were actively watching the television.

On October 23, 2014, the "Recreation Participation" logs were reviewed for Resident #002 for August, September and October 2014, and the following was found:
-August: resident actively participated in activities on 5 different days
-September: resident actively participated in activities on 8 different days
-October 1 to 22: resident actively participated in activities on 4 different days

The October 1 to 22, 2014 "Recreation Participation" logs were also reviewed for 6 other residents that reside on this specific unti and the following was found:
-Resident #007: did not actively participate in any activities, the only documentation on their October log sheet is they passively attended a tea group on October 10 and refused to join fun & fitness on October 17.
-Resident #008: only documented activities are October 9 and 16, when the resident attended "Fun & Fitness"
-Resident #009: only documented activities are October 9 and 10, when the resident attended "Fun & Fitness"
-Resident #010: only documented activities are October 10 and 16, when the resident attended "Fun & Fitness"
-Resident #011: only documented activities are October 9 and 16, when the resident attended "Fun & Fitness"
-Resident #012: only documented activities are October 9, 14 and 16, when the resident attended "Fun & Fitness" and that the resident slept through the activity on October 17, 2014.

On these "Recreation Participation" logs, no residents are documented as having any one to one visits. The majority of the residents that are on this unit cannot independently participate or sit through many larger activities that other members of the home enjoy.

On October 23, 2014, Inspector #106 interviewed the Adjuvant and the Activities Coordinator, they both indicated that the activity aide that is regularly assigned to this specific unit was on sick leave and there had been some difficulty with filling the shifts with casual staff members.

The licensee failed to ensure that the activity program includes assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. [s. 65. (2) (f)]

2. Several observations were made of Resident #022 over the course of inspection and during this time they were positioned in front of the TV in a common room. The health care record for Resident #022 was reviewed for information regarding activity involvement.

The "recreation participation" document for Resident #022 for the month of October 2014 was reviewed and between October 1st and October 21, 2014, there was one session of 15 minutes of 1:1 activity documented.

The licensee failed to ensure that the activity program includes, assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. [s. 65. (2) (f)]

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 activity program includes assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. On October 23, 2014, Inspector #106 interviewed the Residents' Council President and they reported that Residents' Council has not reviewed the menu cycle. On October 24, 2014, the inspector interviewed the Food Services Manager, they reported that they gave the meal cycle menu to residents that were present during a happy hour to approve or give input into, but they had not given the menu cycle to the Residents' Council to review. The licensee failed to ensure that the home's menu cycle, (f) is reviewed by the Residents' Council for the home. [s. 71. (1) (f)]

2. During stage one interviews 3 different residents told Inspector #196 that beverages are not always provided between breakfast and lunch.

On Oct 22, 2014, Inspector #106 observed, that the beverage cart was brought to a specific unit at 1014hrs, and the cart sat unused until at 1115hrs Resident #014 asked a visitor for coffee. The visitor stated that they were not allowed behind the nursing desk (where the beverage cart was). At 1120hrs Resident #014 asked a PSW for some coffee, the staff member told the resident there was no coffee but there was juice. The PSW then provided the resident with juice. At 1215hrs the beverage cart was removed from the nursing station by Staff member #S-110.

The licensee failed to ensure that each resident is offered a minimum of, a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner. [s. 71. (3) (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 each resident is offered a minimum of, a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner, to be implemented voluntarily.

WN #12: 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: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. On October 23, 2014, during an interview with the Residents' Council President, they reported that the council has not reviewed the meal and snack times. On October 24, 2014, Inspector #106 interviewed the Food Services Manager and they reported that Residents' Council has not reviewed the meal and snack times. They also stated that they thought those times "were set in stone".

The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. [s. 73. (1) 2.]

2. During the inspection on a specific unit kitchenette Resident #015 was observed eating their main entree. No staff were present nor observed within the vicinity of the resident.

Registered staff member #S-112 was informed and questioned whether this resident was to be left unsupervised during a meal or while eating. Staff member #S-112 reported that the resident should have been supervised by a staff member. They also reported that the resident was missed at supper time and had not been brought into the dining room, and didn't have their supper until it was noted after the meal.

The current care plan was reviewed for information related to nutritional care and it indicated that resident #015 had swallowing problems and was to be supervised by staff in dining room according to facility policy. During the inspection Resident #015 was not provided with monitoring during their supper meal.

The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: Monitoring of all residents during meals. [s. 73. (1) 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 the home has a dining and snack service that includes, at a minimum, the following elements: Monitoring of all residents during meals, specifically in regards to resident #015, to be implemented voluntarily.

WN #13: 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:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

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:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

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:
4. Consent. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. During the inspection Resident #020 was observed at 1030hrs, sitting in their chair with a restraint applied, in a common TV room.

The current care plan was reviewed and it included the focus of applying the restraint to prevent falls. The "Resident Observation and Monitoring Form" for the month of October 2014, was reviewed for documentation regarding the use of Restraints and several shifts were recorded as use of chair the restraint for the day and evening shifts.

An interview was conducted with Staff member #S-113 and they reported that the hourly monitoring record for restraint/PASD use are kept on the nursing desk. All of these forms are stapled together and include areas for PSW and registered staff to initial and note the resident's response, type of restraint/PASD, and repositioning. The staff member confirmed with the inspector that there was no hourly monitoring record in use on October 21, 2014, despite the restraint being utilized by the resident.

The licensee has failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose [s. 110. (2) 3.]

2. The October 1-21, 2014, "Hourly Monitoring Record" for Resident #001 was reviewed by Inspector #106, which indicated that a member of the registered staff did not document that they reassessed the resident's condition and evaluated the effectiveness of restraining the resident with specific restraints, at least every eight hours on the following days:
-October 6, 2014, there was no documentation by registered staff until 1500 hrs, the restraints were applied at 0600hrs.
-October 5, 2014, there was no documentation by registered staff until 1500hrs, the restraints were applied at 0645 hrs.
-October 3, 2014, there was no documentation by registered staff until 1500hrs, the restraints were applied at 0700hrs.

The licensee failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when

necessary based on the resident's condition or circumstances. [s. 110. (2) 6.]

3. During the inspection Resident #020 was observed sitting in their chair with a specific restraint applied in a common TV room. Upon review of the resident's health care record, it was noted that the use of a restraint is recorded as being used on a daily basis on the resident observation and monitoring form completed by the PSWs.

Staff member #S-110 confirmed with Inspector #196 that the registered staff initials on the "Hourly monitoring record" are to acknowledge that the resident has been reassessed and repositioned. On October 21, 2014, Staff member #S-113 confirmed to the inspector that a "Hourly monitoring record" was not being used for resident #020.

A review of Resident #020's health care records identified that a member of the registered nursing staff had not reassessed the resident's condition and the effectiveness of the restraining, specifically the use of a tilt wheelchair, every eight hours as is required.

The licensee has failed to ensure that where a resident is being restrained by a physical device under section 31 of the Act: 6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. [s. 110. (2) 6.]

4. On October 23, 2014, Inspector #106, reviewed the "Personal Assistance Services Device Consent Form" for Resident #001, which indicated that, on September 27, 2010, the resident's family member consented to the use of a specific restraint. The form does not indicate that other restraints that are used by the resident were consented to.

The inspector reviewed Resident #001's physical restraint/PASD "Hourly Monitoring Record", which indicates that restraints that were not consented to were being used on a daily basis for this resident.

During this inspection the inspector observed the resident restrained by both a restraint with consent and a restraint that consent was not obtained for. 2 PSWs that were interviewed both confirmed that the resident is restrained by both restraints but, the documented consent is only for use of one of the restraints.

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: 4. Consent. [s. 110. (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 where a resident is being restrained by a physical device under section 31 of the Act: 6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances, specifically in regards to residents #001 and #020, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. On October 15, 2014, at 1200hrs, Inspector #196 found a container labelled "Canesten-Hydrocortisone" for Resident #016 on the resident's bedside table.

On October 15, 2014, at 1225hrs, on a specific unit, the door to a storage room behind the nursing station was observed to be propped open and there were no staff within the vacinity. A treatment cart inside the room had several containers of prescription labelled creams on the top surface. The prescription creams included:
-Clotrimazole 1%
-Hydrocortisone Acetate
-Clotrimaderm/Hydrocortisone
-Diclofenac 5% in Diffusimaz
-Clotriderm

Inspector #196 brought this to the attention of Registered staff member #S-114 and they confirmed that this door to the storage room should have been locked.

The licensee of a long-term care home failed to ensure that, (a) drugs are stored in an area or a medication cart, (ii) that is secure and locked. [s. 129. (1) (a) (ii)]

2. On October 22, 2014, at 1527hrs, Inspector #597 interviewed Staff member #S-115 regarding narcotic and controlled drug storage. Narcotics are double locked in medication cart. Narcotics are signed out on MAR and Individual Administration Record. Lorazepam that is ordered routinely and prn, was not double locked.

Registered staff member # S-104 confirmed that narcotics are double locked in medication cart, however, Lorazepam is kept in the bottom drawer of the cart and not double locked.

The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. [s. 129. (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 controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart and that, drugs are stored in an area or a medication cart, that is secure and locked, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. During a stage 1 family interview it was reported to Inspector #106 that a specific unit felt cold. On October 22, 2014, at 1830hrs, Inspector #106 took temperatures on this unit with a "Marathon" thermometer and found that the temperature in and around the unit was 20.3.

On October 23, 2014, at 0940hrs, the temperature in Resident #002's room was 20.1 degrees Celsius and the temperature in one of the tv lounges was 19.9 degrees Celcius.

The licensee has failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. [s. 21.]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. On October 22, 2014, Inspector #106, requested that DOC provide the investigation documentation that the home completed in regards to 3 incidents of abuse that occurred in 2013, by Resident #005 towards Resident #013.

The DOC indicated that the ADOC had completed the investigation and their findings were captured in progress notes and in a notebook. The inspector asked that the DOC provide the progress notes that contained the ADOC's investigation into the incidents of abuse and the notes from the notebook.

Inspector #106 reviewed the progress notes that were provided by the DOC, there were 2 notes that were completed by the ADOC. One note described the 2nd incident of abuse that was reported to the ADOC by a visitor. The second note is a brief summary of a meeting between the ADOC, Resident #005's POA and Staff member #S-116.

On October 24, 2014, the ADOC provided a copy from the notebook that contained additional investigation notes. This was reviewed by the inspector and it only provided dates of the incidents and possible dates and times of interviews, but no further documentation to indicate what was actually done during the home's investigation into the incidents of abuse.

The licensee failed to ensure that, (a) every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated. [s. 23. (1) (a)]

WN #17: 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. Critical Incident Report and progress notes for Resident #005 indicate that Resident #005 abused Resident #013 in 2013. The home did not report this abuse to the Director immediately.

The licensee failed to ensure that, 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: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm. [s. 24. (1)]

2. A Critical Incident Report was submitted to the MOHLTC, for an incident of alleged verbal abuse from a staff member to a resident in the home. An interview was conducted with Staff member #S-117 and it was determined that the incident was not reported to the Director immediately as they did not have access to the Critical Incident System and that it is the ADOC's responsibility.

It was confirmed to the inspector by the ADOC, that this incident was not reported to the MOHLTC immediately and not until after the home's investigation concluded and the allegations were substantiated.

The licensee has failed to ensure that 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: 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. [s. 24. (1)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. Inspector #597 interviewed Staff member #S-106, who identified themself as the RPN responsible for nail care on unit. They stated that Resident #041 refuses nail care. Staff have tried different interventions without success. The resident's toenails were unkempt and the resident was wearing socks as a result. Staff member #S-106 stated that they were afraid that resident would fall as a result. Resident observed to be wearing gripper socks at all times during the inspection.

The licensee has failed to ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. [s. 35. (1)]

2. During an interview with Staff member #S-101 on October 23, 2014, they stated that resident is very resistive to nail care and multiple interventions have been tried without success.

The resident Monitoring Addendum was reviewed by Inspector #597, notes dated November 14, 2014, November 17, 2014, November 28, 2014, March 2, 2014, March 23, 2014, and March 30, 2014, and nail care was noted as not completed on all dates.

Inspector #597 observed during the course of the RQI, that several of Resident #041's fingernails were long and jagged and that the resident was reluctant to show inspector their nails.

The licensee has failed to ensure that each resident of the home receives fingernail care, including the cutting of fingernails. [s. 35. (2)]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (1) Every licensee of a long-term care home shall ensure that,
(a) a package of information that complies with this section is given to every resident and to the substitute decision-maker of the resident, if any, at the time that the resident is admitted; 2007, c. 8, s. 78. (1).
(b) the package of information is made available to family members of residents and persons of importance to residents; 2007, c. 8, s. 78. (1).
(c) the package of information is revised as necessary; 2007, c. 8, s. 78. (1).
(d) any material revisions to the package of information are provided to any person who has received the original package and who is still a resident or substitute decision-maker of a resident; 2007, c. 8, s. 78. (1).
(e) the contents of the package and of the revisions are explained to the person receiving them. 2007, c. 8, s. 78. (1).

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(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. 78 (2)
(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. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in

the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The licensee's "Resident Admission Handbook" was reviewed by Inspector #196 for the required information. On page six of the handbook it refers to contacting the Long Term Care Area Office in Sudbury and provides the toll free number as well as the office phone number. In addition, it provides contact information for the previous Minister of Health. The address for the Director is incorrect and has not been updated with the current address.

The contents of the "Resident Admission Handbook" had not been updated and revised with current Ministry of Health contact information. The licensee failed to ensure that, (c) the admission package of information is revised as necessary. [s. 78. (1) (c)]

2. An interview was conducted with the Administrator on October 24, 2014, to review the reported information noted on the admission process confirmation checklist. The Administrator reported that the licensee's policy to promote zero tolerance of abuse and neglect of residents is not included in the admission package provided to residents and their substitute decision makers.

The licensee has failed to ensure that the admission package of information shall include, at a minimum, (c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents. [s. 78. (2) (c)]

WN #20: 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. On October 14, 2014, during the lunch meal service on unit 4, Inspector #106 observed the following:
-a staff member who was wearing gloves was observed to touch their face, clear tables, scrape dirty plates and then serve residents their meals. The staff member was observed to do this multiple times during the meal observation and was not observed to practice hand hygiene at any time.
The licensee failed to ensure that that all staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

2. On Oct 22, 2014 at 1210 on Unit 1 - Registered staff member #S-115 was observed by Inspector #597 to pour pill for a resident into their hand and then put the pill into medication cup before administering to the resident.

The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

Issued on this 25th day of February, 2015

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

Original report signed by the inspector.