Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 29, 2015	2014_298557_0024	T-084-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE DISTRICT OF THE MUNICIPALITY OF MUSKOKA
98 Pine Street BRACEBRIDGE ON P1L 1N5

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

THE PINES
98 PINE STREET BRACEBRIDGE ON P1L 1N5

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

VALERIE PIMENTEL (557), ANN HENDERSON (559), LYNN PARSONS (153)

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): December 22, 23, 24, 29, 30, 31, 2014, January 2, 5, 6, 7, 8 and 9, 2015.

during the RQI the following Critical Incidents were inspected: T-214-14, T-279-14, T-553-14 and T-7419-14.

During the course of the inspection, the inspector(s) spoke with administrator (AD), director of care (DOC), assistant director of care (ADOC), support service manager (SSM), volunteer coordinator, community coordinator, dietary manager (DM), registered nursing staff, personal support workers (PSW), housekeeping aid, physiotherapy assistant (PTA)

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

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

Specifically failed to comply with the following:

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

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

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

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

The inspector observed on two occasions in December 2014, resident #4's left eye to have discharge present. The inspector and an identified staff member observed the resident's left eye to have discharge present.

During an interview an identified PSW stated the resident frequently has discharge present on his/her eyes over periods of time.

Record review revealed the resident's written plan of care identified activities of daily living and included tub baths, hair care and non-specific personal hygiene with all aspects of care. The care plan did not specify the resident had an eye discharge problem and required additional eye care.

The registered nursing staff and charge nurse confirmed the resident was prone to having eye discharge and the written plan of care did not set out planned eye care. [s. 6. (1) (a)]

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

Documentation review and an interview with resident #4 revealed the resident has chronic constant pain due to a medical diagnosis. In December 2014, the inspector asked the resident if he/she was experiencing pain and the reply was "always and constant". The most recent minimum data set (MDS) results failed to reveal the resident had pain and the resident confirmed the nurse did not ask him/her.

The lead for the pain team confirmed the resident has chronic pain and the plan of care has not been based on the needs of that resident. [s. 6. (2)]

3. 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.

Record review revealed resident #13 uses a continence device. The registered staff are to change the continence device as per the physician's order every four weeks.

On an identified date in November 2014, the continence device was scheduled to be changed. The Treatment Administration Record documentation instructed staff to review a progress note, however, there was no documentation in the progress notes regarding the continence device being changed. The registered nursing staff confirmed there was no documentation entered in the progress notes.

Interview with the DOC confirmed there were no continence devices in the home and these devices were on back order. The DOC confirmed the continence device was not changed as specified in the plan of care every four weeks. [s. 6. (7)]

4. Record review of resident #13's written plan of care identified the resident required to be physically restrained. Staff were to check the resident every hour for safety and repositioned every two hours when the lap belt was engaged.

In December 2014, the inspector observed the resident over a two hour and fifteen minute period, the resident was not checked hourly or repositioned every two hours when the restraint was engaged.

Interviews with the registered nursing staff and DOC confirmed that the resident was not checked every hour for safety and repositioned every two hours when the restraint was engaged and the care set out in the resident's plan of care was not provided as specified in the plan. [s. 6. (7)]

5. Record review and staff interviews identified resident #3 as a high fall risk and hip protectors to be worn at all times. Entries in the progress notes identified the following:
In October 2014, a post fall assessment revealed the resident was not wearing hip protectors.
In December 2014, there were no hip protectors available that morning, and
In November 2014, the resident's hip protectors were found after evening care and were not put on the resident.

The lead for the fall team confirmed the care set out in the plan was not provided to the resident as specified in the plan. [s. 6. (7)]

6. Record review of resident #4's written plan of care identified the resident should have yellow tape on the wheelchair to identify he/she is prone to falls and a chair alarm in place while in the wheelchair.

The inspector and identified staff members observed in January 2015, the resident did not have either yellow tape on the wheelchair or the chair alarm in place.

Staff interviews with identified staff and the DOC confirmed the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

7. The licensee failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care.

Record review identified resident #11 as having an infection in August 2011, upon return

from hospital; however, the diagnosis was not recorded in the clinical record until December 2014.

The written plan of care directs staff to minimize the risk of transmission to others, use contact precautions when providing personal care and complete good environmental cleaning and infection control measures to ensure surfaces are disinfected regularly to prevent the spread of infection.

PSW interviews revealed staff were unclear which personal protective devices were to be worn during personal care of the resident; a PSW stated he/she wore gloves and a gown from a cupboard at the end of the hall way, an identified housekeeper and registered nurse did not know the resident had an infection and during a recent room change the signage had not been transferred to the resident's new room.

The DOC confirmed not all staff were aware the resident was diagnosed with an infection and the applicable precautions to be taken when providing care to this resident. [s. 6. (8)]

8. The licensee has failed to ensure the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change.

Record review of resident #9 revealed the resident's pain assessment was to be completed every three months. The pain assessment was completed as follows: twice in 2011, three times in 2012, twice in 2013, and three times in 2014. The physician reviewed the resident's pain medications every 3 months and made no adjustments and the charge nurses had left communications for the physician to reassess as the resident's pain was not being managed. The pharmacist had not reviewed the resident's medications since December 2013. The resident's pain had been increasing and review of the breakthrough pain medications confirmed the monthly increases.

Interviews with the registered nursing staff and DOC confirmed that the resident was not reassessed, the plan of care was not reviewed and revised to meet the care needs of the resident. [s. 6. (10) (b)]

9. The inspector observed resident #11 three times in December 2014, in a tilted wheelchair with a chair alarm in place.

Record review identifies the resident as requiring a wheelchair to transport the resident to

and from all locations.

Staff interviews revealed they are unsure to what degree or when to tilt the wheelchair and they guess. The chair alarm was put in place a while ago according to the PSWs. The plan of care does not direct staff to tilt the wheelchair or use a chair alarm at any time.

An identified registered nurse confirmed that the resident's plan of care was not reviewed and revised to meet the care needs of the resident. [s. 6. (10) (b)]

10. During the inspection resident #12 identified that he/she continues to have pain. Record review of resident #12 identified in the written plan of care that the resident had pain. The interventions were - to administer pain medication as per doctor's orders and note the effectiveness, give medication for breakthrough pain when necessary and to receive additional interventions/treatments to the affected area.

An identified registered staff member revealed these interventions had been discontinued by the physician and the written plan of care had not been updated.

Staff interviews with the registered nursing staff and DOC confirmed resident #12 was not reassessed and the plan of care was not revised when the resident's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that there is a written plan of care for each resident that sets out the planned care for the resident, sets out clear directions to staff and others who provide direct care to the resident, the resident has been provided the opportunity to participate fully in the development and implementation of the plan of care, to ensure that the care set out in the plan of care is provided to the resident as specified in the plan and to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to protect residents from abuse by anyone.

Documentation review identified resident #15 as having wandering/exit seeking behaviors. Staff were directed to ensure the identified safety device was applied to the resident, observe for signs of escalating behaviors, redirect the resident when wandering/exit seeking and complete the dementia observation scale (DOS) tool to note and record behaviors.

Record review and staff interviews revealed resident #15 had been verbally and physically abusive to resident #26 and physically and sexually abusive to resident #16.

In February 2014, resident #15 entered resident #26's room, lowered the bed side rail, lifted resident #26 from the bed, carried the resident out into the hallway and staff found resident #26 on the floor and resident #15 standing beside him/her. After an assessment resident #26 was found to have received a skin tear.

The home implemented in addition, a motion sensor alarm facing the door on resident #15's room which alerts staff when the resident exits the room. Staff revealed on occasions resident #15 used the connecting bathroom to exit into the hallway.

In April 2014, resident #15 entered resident #16's room and closed the door. Staff heard a noise, entered the room and found resident #16 on the floor undressed from the waist down. Resident #15 was dressed and standing over the resident.

An identified staff member revealed resident #16 had been fully dressed during morning care and is unable to undress him/herself.

In an interview the DOC confirmed the home had failed to protect resident #16 and #26 from abuse. [s. 19. (1)]

2. When resident #17 was admitted transfer documentation revealed the resident had a history of aggression towards residents of the opposite sex from when the resident lived in another Long Term Care setting.

Staff interviews confirmed the plan of care did not identify any interventions for physical aggression.

Record review and staff interviews revealed resident #17 had been physically abusive to resident #14. In January 2014, resident #17 entered a room and hit resident #14 several times across the face leaving red welts, pushed the resident to the floor and attempted to kick him/her.

In an interview the DOC confirmed the home had failed to protect resident #14 from abuse. [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 protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff and o protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Record review and staff interviews identified resident #17 as having responsive behaviours. Staff revealed the resident is known to have a history of aggression since admission and following an incident in January 2014, with resident #14, when resident #17 was transferred to the hospital and admitted. When the resident returned to the home he/she was relocated to a different home area.

Registered staff members confirmed in an interview, strategies had not been developed and implemented to respond to resident #17's responsive behaviours. [s. 53. (4) (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 for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible and to ensure that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

Record review identifies resident #11 as requiring a wheelchair to transport the resident to and from all locations. During the inspection resident #11 was observed in a tilt wheelchair. Staff interviews revealed the resident is not able to get out of the chair when it is tilted. Staff then stated this wheel chair used to belong to another resident and now they can tilt the chair to keep the resident in the wheelchair.

An identified registered nurse confirmed the tilt wheelchair was a restraint which stopped the resident from getting out of the wheelchair and a physician's order had not been received for its use. [s. 110. (2) 1.]

2. The licensee has failed to ensure that the following requirements are met where a resident is being restrained by a physical device: the resident is released from the physical device and repositioned at least once every two hours.

Record review revealed resident #13 is to have a safety device engaged in the wheelchair for safety and to prevent falls. The resident is to be checked every hour for safety and repositioned every 2 hours when restraint is in use. The resident is not capable of removing his/her safety device.

In December 2014, the inspector observed resident #13 in a tilt recliner wheelchair positioned at a 45 degree angle with a safety device in place. The resident remained in the same position for greater than two hours, until this was brought to the attention of the registered nursing staff. During this time period an identified PSW entered the resident's room to remove two other residents who were in the entrance to this resident's room. The PSW did not reposition or release the resident's safety device.

Interviews with the registered nursing staff and the DOC confirmed the staff did not reposition or release the resident's restraint once every two hours. [s. 110. (2) 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 a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining and to ensure that the following requirements are met where a resident is being restrained by a physical device, the resident is released from the physical device and repositioned at least once every two hours, to be implemented voluntarily.

WN #5: 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. The licensee failed to ensure that every resident's right to be cared for in a manner consistent with his or her needs is fully respected.

During an interview with resident #12 a strong lingering odor was present. The resident stated he/she "does not like to smell like urine". Observation of the resident on three occasions in December 2014, confirmed a prescence of a strong urine odor.

Record review revealed the resident has a continence device in place. Interviews with identified staff indicated there may be some urine spillage onto the resident's clothing and/or wheelchair cushion when emptying the continence device.

Interview with the registered nursing staff and DOC confirmed there was a strong lingering odor and the resident was not cared for in a manner to meet his/her needs. [s. 3. (1) 4.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with.

Review of clinical records and staff interviews revealed staff had failed to follow policy 01 -28-01 Responsive Behaviours Management.

In January 2014, a focused behaviour flow sheet was started for resident #17. The policy directs staff to complete forms in full and the focused behaviour flow sheet directs staff to record hourly.

Review of the focused behaviour flow sheet identified there were fourteen occasions in February and four occasions in March 2014, where the staff failed to document in the focused behavioral flow sheets.

An interview with the DOC confirmed staff failed to follow the home's policy and fully complete the documentation. [s. 8. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily accessed and used by residents, staff and visitors at all times.

The inspector observed in December 2014, in resident #12's bathroom when the call bell string was pulled it would separate from the green adapter which was connected to a short connector; this was confirmed with a PSW. On January 2, 2015, the inspector and an identified staff member went to check the resident's call bell in the bathroom. The call bell was separated and the long call string was lying on the bathroom counter.

The resident said it had broken off and not been replaced earlier in the week and the problem had existed for a long time.

Interviews with the registered nursing staff and DOC confirmed they were not aware of this problem and it had not been reported to the registered nursing staff. The home did not ensure that the communication system could be easily accessed by the resident. [s. 17. (1) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the requirements of this section are met with respect to every plan of care, a plan of care is based on, at a minimum,interdisciplinary assessment of the resident's continence, including bladder and bowel elimination.

Record review revealed resident #13 did not have an interdisciplinary assessment by members of the team. The resident's plan of care was completed by the nursing staff. There was no assessment regarding continence completed by other team members or in coordination with them.

Staff interviews with the registered staff and DOC confirmed the resident did not receive an interdisciplinary assessment. [s. 26. (3) 8.]

2. The licensee has failed to ensure that a plan of care is based on, at a minimum, interdisciplinary assessment of the resident's skin condition, including altered skin integrity.

The inspector observed resident #4 to have a small abrasion on the right cheek with a scab. An interview with an identified PSW confirmed the abrasion had been there for approximately a month. An identified registered nursing staff member revealed he/she had no knowledge the resident had an abrasion.

Record review revealed there was no identification of this abrasion in the progress notes and no skin assessment was completed for it.

Interviews with the registered nursing staff confirmed there was no interdisciplinary assessment completed with respect to the resident's abrasion. [s. 26. (3) 15.]

WN #9: 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. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint by a physical device is included in the plan of care.

During the inspection resident #11 was observed in a tilt wheelchair. Staff interviews revealed the home donated the chair to the resident after the physiotherapist recommended a wheelchair. Staff further revealed the resident last attempted to get out of the wheelchair in February 2014.

An identified registered nurse confirmed the tilt chair was a restraint and was not included in the plan of care. [s. 31. (1)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving the Residents' Council advice related to concerns or recommendations.

The Residents' Council minutes for September 2014, identified the Residents' Council had requested:
1- Hallway to the community room on the second floor to be decorated. This will help to lower sound levels, activity staff is to follow up with this request, and
2- There can be other entertainment options on Thursday evenings.

Review of the minutes for October 2014, identified concerns the residents may hit their knees on the lower shelf of the table and maintenance will look at a time and date for the removal of the shelf.

An interview with the Residents' Council president and administrator confirmed concerns and/or recommendations are not always responded to in writing to Residents' Council within 10 days. [s. 57. (2)]

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the menu cycle is reviewed by the Residents' Council.

Interviews with the president of Residents' Council and DM confirmed the dining and snack service including a review of the meal and snack times had not occurred at Residents' Council. [s. 71. (1) (f)]

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining and snack service includes a review of the meal and snack times by the Residents' Council.

Interviews with the president of the Residents' Council and the DM revealed the menu cycle was reviewed at the food committee which is not a sub-committee of the Residents' Council. The president and DM confirmed the menu cycle had not been reviewed by Resident Council. [s. 73. (1) 2.]

Issued on this 3rd day of February, 2015

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

Original report signed by the inspector.