Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELISSA CHISHOLM (188)
Inspection No. / No de l'inspection :	2011_099188_0019
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Oct 4, 5, 6, 7, 11, 12, 13, 17, 21, 24, 2011
Licensee / Titulaire de permis :	THE CITY OF GREATER SUDBURY 200 Brady Street, PO Box 5000 Stn A, SUDBURY, ON, P3A-5P3
LTC Home / Foyer de SLD :	PIONEER MANOR 960 NOTRE DAME AVENUE, SUDBURY, ON, P3A-2T4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	TONY PARMAR

To THE CITY OF GREATER SUDBURY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
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.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,

vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure that an identified resident is properly fed in a manner consistent with the resident's needs.

Grounds / Motifs :

1. 1. Inspector reviewed a mandatory report submission to the Director. This mandatory report contained information related to staff behaviour in relation to an identified resident. This mandatory report identified the resident was not provided with nutritional care. The licensee failed to ensure that the identified resident who requires total staff assistance was properly cared for in a manner consistent with his/her needs. [LTCHA 2007, S.O. 2007, c.8, s.3(1)(4)]

2. While conducting an inspection related to the above noted mandatory report, the inspector observed during a meal service a PSW attempting to assist a resident but then stopped stating loudly that due to the resident's responsive behaviours the PSW would not be continuing to assist the resident. The PSW continued to discuss the resident's behaviours in negative way towards the inspector. Inspector did not observe the resident exhibit any behaviours at any time during the interaction with the PSW. Upon returning to the dining room it was observed that other staff were assisting the resident and that this resident was not exhibiting any responsive behaviours. The licensee failed to ensure that the identified resident, who requires total staff assistance, was cared for in a manner consistent with his/her needs. [LTCHA 2007, S.O. 2007, c.8, s.3(1)(4)] (188)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 24, 2011

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
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.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Order / Ordre :

The licensee shall ensure that restraining of a resident by a physical device is included in a resident's plan of care only if a physician or registered nurse in the extended class has ordered the restraining.

Grounds / Motifs :

1. Inspector reviewed the health care record for an identified resident. Inspector observed this resident using a lap belt restraint during this inspection. Inspector reviewed the signed consent form for this restraint which was signed by the resident's Power of Attorney (POA). Inspector could not locate a physician's order for this restraint. The inspector spoke with two members of the registered nursing staff who confirmed there should be a physician's order for the physical restraint. The licensee failed to ensure the restraint plan of care includes an order by the physician. [LTCHA 2007, S.O. 2007, c.8, s.31(2)(4)] (188)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 24, 2011

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee shall ensure that all drugs are administered to an identified resident, and all resident's in the home, in accordance with the directions specified by the prescriber.

Grounds / Motifs :

1. Inspector reviewed the health care record for an identified resident. Inspector noted a physician's order for a medication. Inspector noted in reviewing the Medication Administration Record (MAR) that the resident did not receive the medication as prescribed. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. [O.Reg. 79/10, s.131(2)] (188)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 24, 2011

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Order / Ordre :

The licensee shall ensure that the lap belt and wheelchair for an identified resident are appropriate based on the resident's condition. The licensee shall ensure that, as part of the home's restorative care program, when equipment, including wheelchairs and physical restraints, are used with respect to residents, the equipment is appropriate for that resident based on the resident's condition.

Grounds / Motifs :

1. The licensee failed to ensure the equipment, specifically the position aid of a lap belt used for a resident was appropriate based on the resident's condition. The resident had a lap belt applied to the resident's wheelchair upon admission. Consent was obtained for this lap belt.

Inspector reviewed the progress notes and electronic referrals to PT/OT for the identified resident. Inspector noted that several electronic referrals over a short time period were sent to PT/OT identifying concerns related to the resident's wheelchair and lap belt.

Inspector noted that the wheelchair and lap belt were assessed by the occupational therapist; however no changes were made at that time.

Inspector noted that additional electronic referrals were sent following the assessment again identifying concerns related to the resident's wheelchair and lap belt.

Inspector noted that the day following the submission of additional referrals that the identified resident sustained a fall. The licensee failed to ensure the lap belt for an identified resident was appropriate based on the resident's condition. [O.Reg. 79/10, s.30(1)(2)] (188)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 24, 2011

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

Issued on this 24th day of October, 2011

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : MELISSA CHISHOLM

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 4, 5, 6, 7, 11, 12, 13, 17, 21, 24, 2011	2011_099188_0019	Complaint

Licensee/Titulaire de permis

THE CITY OF GREATER SUDBURY
200 Brady Street, PO Box 5000 Stn A, SUDBURY, ON, P3A-5P3

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

PIONEER MANOR
960 NOTRE DAME AVENUE, SUDBURY, ON, P3A-2T4

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

MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Manager of Resident Care, Program Coordinators, the Manager of Physical Services, the Supervisor of Housekeeping & Laundry, the Manager of Therapeutic Services, Registered Staff members, Personal Support Workers (PSWs), Physiotherapists, Physiotherapist Assistants, Nutritional Aids, Housekeeping staff, front office staff, residents and families.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions, reviewed health care records, reviewed various policies and procedures, reviewed critical incident reports and observed dining room service.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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 subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
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.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Inspector reviewed a mandatory report submission to the Director. This mandatory report contained information related to staff behaviour in relation to an identified resident. This mandatory report identified the resident was not provided with nutritional care. The licensee failed to ensure that the identified resident who requires total staff assistance was properly cared for in a manner consistent with his/her needs. [LTCHA 2007, S.O. 2007, c.8, s.3(1)(4)]

2. While conducting an inspection related to the above noted mandatory report, the inspector observed during a meal service a PSW attempting to assist a resident but then stopped stating loudly that due to the resident's responsive behaviours the PSW would not be continuing to assist the resident. The PSW continued to discuss the resident's behaviours in negative way towards the inspector. Inspector did not observe the resident exhibit any behaviours at any time during the interaction with the PSW. Upon returning to the dining room it was observed that other staff were assisting the resident and that this resident was not exhibiting any responsive behaviours. The licensee failed to ensure that the identified resident, who requires total staff assistance, was cared for in a manner consistent with his/her needs. [LTCHA 2007, S.O. 2007, c.8, s.3(1)(4)]

Additional Required Actions:

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

WN #2: 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 subsections:

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:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
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.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. Inspector reviewed the health care record for an identified resident. Inspector observed this resident using a lap belt restraint during this inspection. Inspector reviewed the signed consent form for this restraint which was signed by the resident's substitute decision maker. Inspector could not locate a physician's order for this restraint. The inspector spoke with two members of the registered nursing staff who confirmed there should be a physician's order for the physical restraint. The licensee failed to ensure the restraint plan of care includes an order by the physician. [LTCHA 2007, S.O. 2007, c.8, s.31(2)(4)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs
Specifically failed to comply with the following subsections:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

Inspector reviewed the health care record for an identified resident. Inspector noted a physician's order for a medication. Inspector noted in reviewing the Medication Administration Record (MAR) that the resident did not receive the medication as prescribed. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. [O.Reg. 79/10, s.131(2)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements
Specifically failed to comply with the following subsections:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

The licensee failed to ensure the equipment, specifically the position aid of a lap belt used for a resident was appropriate based on the resident's condition. The resident had a lap belt applied to the resident's wheelchair upon admission. Consent was obtained for this lap belt.

Inspector reviewed the progress notes and electronic referrals to PT/OT for the identified resident. Inspector noted that several electronic referrals over a short time period were sent to PT/OT identifying concerns related to the resident's wheelchair and lap belt.

Inspector noted that the wheelchair and lap belt were assessed by the occupational therapist; however no changes were made at that time.

Inspector noted that additional electronic referrals were sent following the assessment again identifying concerns related to the resident's wheelchair and lap belt.

Inspector noted that the day following the submission of additional referrals that the identified resident sustained a fall. The licensee failed to ensure the lap belt for an identified resident was appropriate based on the resident's condition. [O.Reg. 79/10, s.30(1)(2)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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 subsections:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

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.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
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.
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.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
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:
1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. Inspector spoke with the Manager of Therapeutic Services. It was identified to the inspector that the home does not have specific manufacturer's instructions on the application of lap belts. It was identified that education and direction is provided to front line staff emphasizing the importance of applying lap belts properly, specifically making sure the belt is not loose and that the resident is properly sitting in the wheelchair. It was identified that loose belts are one of the biggest concerns observed with lap belt use.

Inspector observed an identified resident in the dining room. Inspector noted that this resident was not sitting correctly in the wheelchair. Inspector noted that there was a space of approximately 20 centimeters between the back of the wheelchair and the resident's back. Inspector observed that the lap belt was not properly positioned over the resident's lap.

Inspector observed an identified resident in the dining room. Inspector observed that this resident's lap belt was applied, however very loose. The inspector was able to freely place her entire hand, turned sideways, in-between the resident and the belt. The inspector observed the resident during super meal service and did not observe any staff member take action to correctly apply or tighten the lap belt. [O.Reg. 110(1)(1)]

2. Inspector reviewed the health care record for an identified resident. Inspector noted a signed consent for restraint use. Inspector was unable to locate any documentation for this restraint including the person who made the order, what device was ordered, and any instructions relating to the order. Inspector spoke with a RPN and a RN who identified there should be a physician's order for the restraint and that they will follow up with the physician. The licensee failed to ensure documentation includes the person who made the order, what device was ordered, and any instructions relating to the order. [O.Reg. 79/10, s.110(7)(3)]

3. Inspector reviewed the health care record for an identified resident. Inspector noted a signed consent for restraint use. Inspector was unable to locate any documentation for this restraint identifying the removal of the device, including time of removal or discontinuance and the post-restraining care. Inspector spoke with a RPN who identified there should be hourly documentation on a form titled "Restraint and Personal Assistance Services Devices (PASDs) Monitoring Record" and this form is completed by PSWs. The inspector, the RPN and two PSWs who were asked by the RPN about the documentation were unable to locate any documentation since the restraint was initiated. The licensee failed to ensure documentation includes the removal of the device, including time of removal or discontinuance and the post-restraining care.[O.Reg. 79/10, s.110(7)(8)]

4. Inspector reviewed the health care record for an identified resident. Inspector noted a signed consent for restraint use. Inspector was unable to locate any documentation for this restraint identifying every release of the device and repositioning. Inspector spoke with a RPN who identified there should be hourly documentation on a form titled "Restraint and Personal Assistance Services Devices (PASDs) Monitoring Record" and this form is completed by PSWs. The inspector, the RPN and two PSWs who were asked by the RPN about the documentation were unable to locate any documentation since the restraint was initiated. The licensee failed to ensure documentation includes every release of the device and repositioning of the resident. [O.Reg. 79/10, s.110(7)(7)]

5. Inspector reviewed the health care record for an identified resident. Inspector noted a signed consent for restraint use. Inspector was unable to locate any documentation for this restraint identifying all assessment, reassessment and monitoring, including the resident's response. Inspector spoke with a RPN who identified there should be hourly documentation on a form titled "Restraint and Personal Assistance Services Devices (PASDs) Monitoring Record" and this form is completed by PSWs. The inspector, the RPN and two PSWs who were consulted by the RPN about the documentation were unable to locate any documentation since the restraint was initiated. RPN identified that restraints are reassessed by the registered nursing staff every eight hours and this is documented on the MAR. RPN provided inspector with a printed copy of the residents MAR. Inspector noted the resident's restraint is not identified or documented on the MAR. The licensee failed to ensure documentation identifies all assessment, reassessment and monitoring, including the resident's response. [O.Reg. 79/10, s.110(7)(6)]

6. Inspector reviewed the health care record for an identified resident. Inspector noted a signed consent for restraint use. Inspector was unable to locate any documentation for this restraint identifying the person who applied the device and the time of application. Inspector spoke with a RPN who identified there should be hourly documentation on a form titled

"Restraint and Personal Assistance Services Devices (PASDs) Monitoring Record" and this form is completed by PSWs. The inspector, the RPN and two PSWs who were asked by the RPN about the documentation were unable to locate any documentation since the restraint was initiated. The licensee failed to ensure documentation includes the person who applied the device and the time of application. [O.Reg. 79/10, s.110(7)(5)]

7. Inspector observed an identified resident in the dining room for three and a half hours. This resident was restrained using a lap belt during the identified observation period. At no time, while being observed by the inspector, during the identified time period was the physical device (lap belt) released. The licensee failed to ensure staff release the resident from the physical device and reposition at least once every two hours. [O.Reg. 79/10, 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 ensuring residents who are restrained by a physical device are released from that device and repositioned at least once every two hours and that all documentation requirements are met for all residents restrained by physical devices, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following subsections:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. Inspector spoke with the Manager of Resident Care, upon entrance to the home on October 4, 2011. The inspector was informed that the home's investigation into identified abuse allegations was completed, however the SDM for the resident involved had not been contacted immediately upon the completion of the investigation. The licensee failed to ensure that the resident and resident's SDM are notified of the results of the alleged abuse or neglect investigation immediately upon the completion. [O.Reg. 79/10, s.97(2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the resident and the resident's SDM are notified of the results of the alleged abuse or neglect investigation immediately upon the completion, to be implemented voluntarily.

WN #7: 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 subsections:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. Inspector entered the home to inspect a critical incident. Inspector noted prior to starting the inspection that the original critical incident report had not been updated since submission. Inspector noted this report identified the home's investigation was still active. During the entrance conference with the Manager of Resident Care it was reported to the inspector that the investigation was completed. At that time the inspector also received a copy of the home's investigation notes and was informed that the critical incident report would be updated. Inspector reviewed the home's investigation notes provided and noted that the investigation was completed three weeks prior to the inspector entering the home. The licensee failed to ensure that the Director is informed of the results of the abuse or neglect investigation. [LTCHA 2007, S.O. 2007, c.9, s.23(2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring the Director is informed of the results of the abuse or neglect investigation, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following subsections:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. O.Reg. 79/10, s.219(1) The intervals for the purposes of subsection 76(4) of the Act are annual intervals.

Inspector spoke with the Manager of Resident Services, upon entering the home on October 4, 2011. In a discussion about how the home retrains staff on the home's prevention of abuse and neglect policy the inspector was informed that the home's Registered Practical Nurses (RPNs) have not participated in the home's annual re-training program as the home does not have enough RPNs to cover shifts while they participate in the home's full day training program. The licensee failed to ensure that all staff receive annual retraining on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents. [LTCHA 2007, S.O. 2007, c.8, s.76(4)]

2. Inspector spoke with a RPN who identified they had not participated in the home's annual retraining program for approximately two and a half years. The RPN identified that this training program includes review of the home's policies, specifically the home's policy to promote zero tolerance of abuse and neglect of residents. This RPN identified the home did not have enough RPNs on staff to replace shifts while they attended training. The licensee failed to ensure that all staff receives annual retraining on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents. [LTCHA 2007, S.O. 2007, c.8, s.76(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 ensuring all staff, including RPNs receive annual retraining on the long-term care home's policy to promote zero tolerance of abuse and any other requirement as identified in the LTCHA, 2007, to be implemented voluntarily.

WN #9: 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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. Inspector spoke with the SDMs for a resident. They reported to the inspector that they had requested to be involved and present during assessments of the resident. They also reported to the inspector that they had requested that these assessments be completed in the resident's mother tongue if possible. Inspector reviewed the progress notes and confirmed these requests. Inspector noted that the assessment was not completed in the resident's mother tongue. Inspector spoke with staff who conducted this assessment who confirmed that the family was not present for the assessment and that this assessment was not completed in the resident's mother tongue. The licensee failed to ensure that the resident's substitute decision-makers were given an opportunity to participate fully in the development and implementation of the resident's plan of care. [LTCHA 2007, S.O. 2007, c.8, s.6(5)]

2. Inspector reviewed the progress notes for a resident. It is identified that the SDMs requested to be notified of all and any changes to the residents medications. The SDMs reported to the inspector that they were not notified following changes to the medication orders. Inspector reviewed the MAR for the resident and noted the changes. Inspector was unable to locate any documentation in the progress notes identifying either SDM was informed of these changes. The licensee failed to ensure that the resident's substitute decision-makers were given an opportunity to participate fully in the development and implementation of the resident's plan of care. [LTCHA 2007, S.O. 2007, c.8, s.6(5)]

3. Inspector reviewed the plan of care for a resident related to toileting and transferring. Under the transferring section of the care plan it identifies the resident requires a two person assist. Under the toileting section of the care plan it identifies the resident requires only one person to assist to transfer. The care plan provides conflicting information with regards to how many staff are required to transfer this resident. The licensee failed to ensure the plan of care provides clear directions to staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c.8, s.6(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 ensuring resident's substitute decision-makers are given an opportunity to fully participate in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. Inspector reviewed the home's policy titled "ABUSE: RESIDENT ABUSE / MISTREATMENT". This written policy to promote zero tolerance of abuse and neglect of residents fails to include an explanation of the duty under section 24 of the Act to make mandatory reports. The licensee failed to ensure their written policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty under section 24 of the Act to make mandatory reports. [LTCHA 2007, S.O. 2007, c.8, s.20(2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management
Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. Inspector reviewed the health care record for a resident. Inspector noted this resident had a fall. Inspector noted this fall was documented in the progress notes but was unable to locate a post-fall assessment that used a clinically appropriate assessment instrument. Inspector spoke with a RPN and a RN who both identified a post-fall assessment should be done using the home's electronic post-fall assessment on Point Click Care (PCC). Both registered staff members and the inspector reviewed this resident's PCC assessments and came to the conclusion that no post-fall assessment, using a clinically appropriate assessment instrument that is specifically designed for falls, was completed. The licensee failed to ensure that when a resident has fallen that they are assessed using a clinically appropriate assessment instrument that is specifically designed for falls. [O.Reg. 79/10, s.49(2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

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;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(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. Inspector reviewed the health care record of a resident. Inspector noted multiple entries in the progress notes completed by registered nursing staff and in the interdisciplinary notes completed by PSWs which identify this resident as refusing personal care and demonstrating physically responsive behaviours towards staff who are trying to provide care. Inspector spoke with two RPNs who confirmed that the resident has refused care and become physically response on different occasions. Inspector reviewed the plan of care for this resident and noted the potential for physical responsive behaviours is not identified or included. There have been no strategies in place to prevent, minimize or respond to this behaviour. It was reported to the inspector by a PSW that they have two staff provide care if the resident is exhibiting these behaviours. The licensee failed to ensure that written strategies including techniques and interventions to prevent, minimize or respond to the responsive behaviour. [O.Reg. 79/10, s.53(1)(2)]

2. Inspector reviewed the health care record of a resident. Inspector noted multiple entries in the progress notes completed by registered staff and the interdisciplinary notes completed by PSWs which identifies this resident as refusing care, specifically oral care. Inspector spoke with various PSWs, RPNs and the Program Coordinator who also identified that this resident often refuses care, specifically oral care. Inspector reviewed the care plan for this resident which identifies the need for staff to provide oral care. Inspector noted that it does not identify that this resident often refuses oral care. It fails to mention any strategies used to respond to this behaviour. Staff identified to the inspector that they will try a different approach, ensure they explain to the resident what they are trying to do and leave and try again in a few minutes. These interventions are not included in the plan of care for this resident. The licensee failed to ensure the behavioural triggers are identified and that strategies are developed and implemented to response to these behaviours for this resident's refusal of care. [O.Reg. 79/10, s.53(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 ensuring all residents who have exhibited responsive behaviours have written strategies including techniques and interventions to prevent, minimize or respond to the responsive behaviours, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. Inspector reviewed the health care record for a resident. The care plan identifies that this resident speaks and understands one language. The admission progress note identifies a request for assessments and direct care to be provided in this language as often as possible. Inspector noted that the assessment completed by staff was not completed in this language. No strategies were utilized to communicate with the resident in their language. The licensee failed to ensure that strategies were implemented to meet the needs of the residents who cannot communicate in the language used in the home. [O.Reg. 79/10, s.43]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 59. Therapy services
Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include,
(a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs; and
(b) occupational therapy and speech-language therapy. O. Reg. 79/10, s. 59.

Findings/Faits saillants :

1. Inspector reviewed the health care record for a resident. Inspector reviewed the physiotherapist's assessment which includes a treatment plan. Inspector spoke with the physiotherapy assistant (PTA) on the unit which this resident resides. This PTA identified that the resident is not currently, or has ever received, treatment through the physiotherapy department. Inspector spoke with the Manager of Therapeutic Services. It was confirmed to the inspector that this resident was not currently receiving any on-site physiotherapy services. It was identified that an assessment had been completed, however that treatment plan was never initiated. The licensee failed to ensure this resident received on-site physiotherapy services based on the assessed need. [O.Reg. 79/10, s.59(a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following subsections:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. Inspector reviewed a critical incident report. Inspector noted that this Mandatory Report related to abuse does not include the names of the individuals who were alleged to have committed abuse. Inspector noted that the names of all other staff members, who witnessed the incident of abuse, were included in the report. The licensee failed to ensure that the report to the Director includes the names of any staff members who were present at the incident. [O.Reg. 79/10, s.104(1)(2)]

2. Inspector reviewed a critical incident report. Inspector noted that this Mandatory Report related to abuse does not include the name of the individual who was alleged of committing abuse. Inspector noted that the names of all other staff members, who witnessed the alleged abuse, were included in the report. The licensee failed to ensure that the report to the Director includes the names of any staff members who were present at the incident. [O.Reg. 79/10, s.104(1)(2)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. Inspector reviewed the health care record for a resident. Inspector noted in the progress notes it identifies this resident as having altered skin integrity. Inspector noted the progress note identifies that treatment was used to dress the wound, however inspector was unable to locate a physician's order for this treatment. Inspector did not locate an assessment, completed by the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment for this identified wound. Inspector spoke with two members of the registered nursing staff who were unable to locate an assessment for this resident's wound, both confirmed and directed the inspector to the unit's wound care book where the assessment and documentation should be kept. The licensee failed to ensure that a resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument. [O.Reg. 79/10, s.50(2)(b)(i)]

2. Inspector reviewed the health care record for a resident. Inspector noted in the progress notes it identifies the resident as having altered skin integrity. Inspector also noted a physician's order with treatment directions. Although this was documented in the progress notes and supported by the physicians order, inspector was unable to locate an assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. Inspector spoke with two members of the registered nursing staff who were unable to locate an assessment for this resident's wound, both confirmed and directed the inspector to the unit's wound care book where the assessment and documentation would be kept. The licensee failed to ensure that a resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument. [O.Reg. 79/10, s.50(2)(b)(i)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. Inspector reviewed the home's policy titled "ABUSE: RESIDENT ABUSE / MISTREATMENT". This written policy to promote zero tolerance of abuse and neglect of residents identifies "Ensure that the resident is protected from further contact with the implicated staff/volunteer" however fails to include any procedures or interventions to assist and support residents for have been abused or neglected. The licensee failed to ensure their written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected. [O.Reg. 79/10, s.96(a)]

2. Inspector reviewed the home's policy titled "ABUSE: RESIDENT ABUSE/MISTREATMENT". The policy identifies who will undertake the investigation but fails to include that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation immediately upon the completion of the investigation (as per O.Reg. 79/10 s.98(2)). The licensee failed to ensure their written policy to promote zero tolerance of abuse and neglect of residents identifies who will be informed of the investigation. [O.Reg. 79/10, s.96(d)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following subsections:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;
(e) continence care products are not used as an alternative to providing assistance to a person to toilet;
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. Inspector reviewed the health care record for a resident. This resident's care plan identifies the resident as incontinent. Inspector was unable to locate an assessment which includes the identification of causal factors, patterns, type of incontinence and potential to restore function with specific intervention which was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. Inspector spoke with two members of the registered nursing staff who confirmed that a continence assessment had not been completed for this resident. They both identified the assessment would have been completed electronically through PCC, both reviewed the resident's PCC assessments confirming one had not been completed. The licensee failed to ensure that a resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. [O.Reg. 79/10, s.51(2)(a)]

2. Inspector reviewed the health care record for a resident. The inspector reviewed the care plan for this resident related to toileting and bowel and bladder continence and noted this resident required total staff assistance. Inspector noted that the plan of care identifies the resident should be toileted before and after meals. Inspector observed this resident before and after the evening meal service (from 14:57h through until 18:25h) and noted the resident was not toileted during this time period. The licensee failed to ensure that the individualized plan of care to promote and manage bowel and bladder continence is implemented. [O.Reg. 79/10 s.51(2)(b)]

Issued on this 1st day of November, 2011

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