Ontario

**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

**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) :** | KELLY-JEAN SCHIENBEIN (158), DIANA STENLUND (163), MARGOT BURNS-PROUTY (106), MELISSA CHISHOLM (188), MONIQUE BERGER (151) |
| **Inspection No. / No de l'inspection :** | 2012_140158_0005 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Date of Inspection / Date de l'inspection :** | Feb 25, 28, 29, Mar 1, 2, 3, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 18, 19, 22, 23, 2012 |
| **Licensee / Titulaire de permis :** | THE CITY OF GREATER SUDBURY<br>200 Brady Street, PO Box 5000 Stn A, SUDBURY, ON, P3A-5P3 |
| **LTC Home / Foyer de SLD :** | PIONEER MANOR<br>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:

Ontario

**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

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**Order # / Ordre no :** 901

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, 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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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).

**Order / Ordre :**

The licensee shall prepare and submit a plan outlining immediate short-term measures and long-term strategies that will be implemented to ensure the resident-staff communication and response system is easily seen, accessed and used by residents, staff and visitors at all times and clearly indicates when activated where the signal is coming from.

This written plan must be submitted in person to Inspector Kelly-Jean Schienbein who will be present in the home on or before March 8, 2012.

**Grounds / Motifs :**

1. The licensee has not ensured that the home is equipped with a resident-staff communication and response system (call bell system) that clearly indicates where the signal is coming from or that the residents had access to a communication system..
On February 29, 2012, inspector checked ten rooms in the home areas of Killarney, Lilac/Mallard and Park Place. Nine of the ten rooms did not have a functioning call bell system in the bathroom that when activated illuminated to the lights outside of the resident's room. [ O.Reg 79/10, s. 17 (1) (f) ]
Resident Versus badges were checked in the same home areas. Three residents residing in those areas did not have functioning Versus badges. [ O.Reg 79/10, s. 17 (1) (a) ] (163)
2. The home did not ensure that the resident-staff communication system (call bell system) clearly indicated where the signal was coming from or that the residents had access to a communication system.
The home conducted a planned testing of its generator on February 29, 2012 at 1005hrs.
During an interview with the IT resource person on March 1, 2012, IT reported to Inspector that on February 29, 2012, IT became aware at approximately 1000 hours that the call bell system for the Lodge, York and Killarney were not functioning. IT reported to the Inspector that IT was not aware that other areas in the home were experiencing a call bell system malfunction until approximately 1900 hrs.
The DOC identified to Inspectors #158, #106, #163 on February 29, 2012 at 1730hrs that an e-mail from IT was received indicating "that the call bell system was all fixed in the home by 1600hrs".
The DOC also identified to Inspectors #158, #106, #163 on February 29, 2012 that manual "silver call bells" were to be in place so that the residents would have access to a communication system.
Ten residents versus badges and the call bells located in the residents' bathrooms in areas Tulip, Trillium, Pine, Poplar and Lodge 1 were randomly tested by Inspector on February 29, 2012 at 1330hrs.
It was observed by Inspector that the bathroom call bell light illuminated outside one resident's room in one unit,

however, the PSW identified that the pager assigned to the resident did not activate. [ O.Reg 79/10, s. 17 (1) (f) ]
A manual silver call bell was not observed in the resident's room. [ O.Reg 79/10, s. 17 (1) (a) ]
The light did not illuminate outside a resident's room or activate a PSW's pager when the resident's versus badge in Pine was pressed. [ O.Reg 79/10, s. 17 (1) (f) ]
A manual silver bell was not observed within the resident's reach. [ O.Reg 79/10, s. 17 (1) (f) ]
A resident 's versus badge illuminated the lights outside the resident's room, however, the inspector observed that the PSW went to the room located across from the resident's room. The PSW identified to the inspector that the pager signaled that the page came from the room across the hall from the resident.[ O.Reg 79/10, s. 17 (1) (f) ]
A silver call bell was not observed within the resident's reach. [ O.Reg 79/10, s. 17 (1) (a) ]
Two other residents' badges did not activate the PSW's pager when pressed. [ O.Reg 79/10, s. 17 (1) (f) ]
A manual silver call bell was not observed in one of the resident's room. A silver call bell was observed on the dresser located in the other resident's room, however, the silver call bell was not within the resident's reach. [ O.Reg 79/10, s. 17 (1) (a) ]
In Lodge 2, a PSW's pager read "Help - # Block ". The PSW stated to inspector, "Where am I to go when it says this." [ O.Reg 79/10, s. 17 (1) (f) ]
The Registered staff member and PSWs on one unit identified to Inspector on February 29, 2012 that there were not enough working pagers available to all the PSW's working on the day shift. The staff identified that a pager only became available when the scheduled staff member left at 1300hrs. [ O.Reg 79/10, s. 17 (1) (f) ]
On February 29, 2012, staff from Trillium, Poplar, lodge 2 and Tulip reported to inspector that communication "interruptions" with the resident's call bell system has been an ongoing issue despite the staff reporting of this issue to management. The staff identified to inspector that they have previously reported to management the following: battery failure, lack of available pagers, receiving pager alerts from areas other than the area they are working in, inability to cancel pages and lack of confidence with the illumination of the light alerts outside resident's rooms. The home is not ensuring that the resident-staff communication system (call bell system) clearly indicates where the signal was coming from and that the residents had access to a communication system.
[ O.Reg 79/10, s. 17 (1) (f) ], [ O.Reg 79/10, s. 17 (1) (a) ]
On March 1, 2012 at 1450h, inspector checked two resident bathroom call bell systems in Lodge 2. The lights outside the resident's room did not illuminate. The PSWs on the unit confirmed that a page was not received. The call bell system in Lodge 2 common room was checked on March 1, 2012 at 1450h. The call bell sounded in the room, however, the lights did not illuminate. The PSWs on the unit confirmed that a page was not received. [ O.Reg 79/10, s. 17 (1) (f) ]
A PSW who worked the evening shift on one unit identified to inspector on March 1, 2012 that the call bell system did not work when they rang for assistance to transfer a resident who is a 2-person mechanical lift. The PSW identified that a delay of half an hour occurred as no other PSW received the page when the resident's bedside call bell was activated. The PSW identified that the lights outside of the resident's room did not illuminate.
[ O.Reg 79/10, s. 17 (1) (f) ] (158)
3. Inspector spoke with a PSW on March 1, 2012 at 1015hrs. The PSW reported that "there are no pagers working on Mallard, it happens probably two times per week". [ O.Reg 79/10, s. 17 (1) (f) ]
A resident on one unit was in a wheel chair outside of their bed room on March 1, 2012 at approximately 1000hrs. Inspector asked a PSW if the resident required a versus badge. The PSW responded the resident " should have one, it is probably lost in the laundry or something." [ O.Reg 79/10, s. 17 (1) (a) ]
Inspector tested the call bells in Lilac/Mallard on March 01, 2012 at 1000hrs. The call bell did not register on a PSW's pager working in that area.[ O.Reg 79/10, s. 17 (1) (f) ]
Inspector tested the call bell in both the shower and tub rooms on Killarney on March 1, 2012 at approximately 1000hrs. A PSW working in the unit indicated to the inspector that the pager was not activated by the pulling of the call bells.[ O.Reg 79/10, s. 17 (1) (f) ] (163)
4. On March 1/12, Inspector spoke with a PSW and a Registered staff member who both stated that they had prior notice from management regarding the planned generator testing and power outage, however, there was no communication that the call bell system was affected until Inspector conducted the testing on the unit

February 29/ 20112 at 1400h. (158)
5. The home's resident – staff communication and response system (call bell system) is not easily used by the residents. The home provides two different styles of resident's versus badges to the residents. The first style is white with an easily pressed button located on its face. The second style is black with a small red rectangular button located on its face which is 0.4 cm by 1.3 cm in size.
Inspector 158 and inspector 163 observed on February 29/2012, that three residents had difficulty pressing the black badge with the small red button without assistance when asked by the inspectors during the testing of the versus system. [ O.Reg 79/10, s. 17 (1) (a) ] (158)
6. The licensee has not ensured that the home is equipped with a resident-staff communication and response system (call bell system) that clearly indicates where the signal is coming from. On February 29/12, inspector checked ten rooms in the home areas of Lodge 2, Scenic, Ramsey, Lilac, Mallard and York . Eight of the ten rooms' lights located outside the residents' rooms in those areas did not illuminate when the call bell system was activated. As well, five of the residents' badges did not register to the corresponding pager.
[ O.Reg 79/10, s. 17 (1) (f) ]
Staff were unaware on Onwatin that the call bell system was not working in this home area when inspector 106 reported her findings to them. [ O.Reg 79/10, s. 17 (1) (f) ] (106)
7. On March 1, 2012 at approximately 1530hrs, Inspector observed a pager on a care cart located in Lilac hallway. The pager was activated twice within three minutes. There were no staff in the area to hear the pager or address the call. The pager was brought by the inspector to the Registered member who at the Lilac/Mallard nursing station.[ O.Reg 79/10, s. 17 (1) (a) ] (158)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Mar 08, 2012

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**Order # /**
**Ordre no :** 001

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, 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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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).

**Order / Ordre :**

The licensee shall fully implement the submitted plan which outlines immediate short-term measures and long-term strategies that will ensure the resident-staff communication and response system is easily seen, accessed and used by residents, staff and visitors at all times and clearly indicates when activated where the signal is coming from by April 27, 2012.

**Grounds / Motifs :**

1. On February 29, 2012, Inspector 163 checked ten rooms in Killarney, Lillac/Mallard and Park Place Units. Nine of the ten rooms did not have a functioning call bell system in the bathroom that, when activated illuminated to the lights outside of the resident's room. The home is not ensuring that the resident call and response system

clearly indicates where the signal is coming from. [O.Reg 79/10, s.17(1)(f)]
On February 29, 2012, Inspector 163 checked resident Versus badges who resided in Killarney, Lillac/Mallard and Park Place Units. Three residents residing in these areas did not have a functioning Versus badge. These residents did not have access to a call bell system. [O.Reg 79/10, s.17(1)(a)] (163)
2. The home's resident – staff communication and response system is not easily used by the residents. The home provides two different styles of Versus badges to the residents. The first style is white with an easily pressed button located on its face. The second style is black with a small red rectangular button located on its face which is 0.4 cm by 1.3 cm in size. On February 29/2012, Inspector 158 and Inspector 163 observed that three residents had difficulty pressing the black badge with the small red button without assistance when asked by the inspectors during the testing of the Versus system. [O.Reg 79/10, s.17 (1)(a)] (158)
3. On March 1, 2012, Inspector 163 spoke with a PSW who reported that "there are no pagers working on Mallard, it happens probably two times per week". The home is not ensuring that the resident call and response system clearly indicates where the signal is coming from. [O.Reg 79/10, s.17(1)(f)]
On March 1, 2012, Inspector 163 observed a resident who was in a wheel chair on Killarney Unit. Inspector observed that the resident did not have a Versus badge. Inspector 163 asked a PSW if the resident required a versus badge. The PSW responded, the resident "should have one, it is probably lost in the laundry or something." The resident did not have access to a call and response system. [O.Reg 79/10, s.17(1)(a)]
On March 1, 2012, Inspector 163 tested the call bells in Lilac/Mallard Unit. The call bell did not register on a PSW's pager who was working in that area. The home is not ensuring that the resident call and response system clearly indicates where the signal is coming from. [O.Reg 79/10, s.17(1)(f)]
On March 1, 2012, Inspector tested the call bell in both the shower and tub rooms on Killarney Unit. A PSW working in Killarney indicated to the inspector that her pager was not activated by the test. The home is not ensuring that the resident call and response system clearly indicates where the signal is coming from. [O.Reg 79/10, s.17(1)(f)] (163)
4. On March 1, 2012, Inspector spoke with a PSW and a Registered staff member who both stated that they had prior notice from management regarding the planned generator testing and power outage, however, there was no communication that the call bell system was affected until Inspector conducted the testing on the unit February 29, 2012 at 1400hrs. The home is not ensuring that the home is equipped with a resident-staff communication and response system that clearly indicates where the signal is coming from. [O.Reg 79/10, s. 17 (1)(f)] (158)
5. On March 1, 2012 at approximately 1530h, Inspector 163 observed a pager in Lilac Unit's hallway on a care cart. The pager was activated twice within three minutes. There were no staff in the area to hear the pager or address the call. The pager was brought by the inspector to the RPN at the Lilac/Mallard Unit's nursing station.
On March 1/2012 at approximately 1000hrs, a resident on Killarney unit was in a wheel chair outside of the resident's room. Inspector #163 asked a PSW if the resident required a Versus badge. The PSW responded, the resident " should have one, it is probably lost in the laundry or something." [O.Reg 79/10, s.17 (1)(a)] (158)
6. On February 29, 2012, Inspector checked ten rooms in Lodge 2, Scenic, Ramsey, Lilac, Mallard and York Units. Eight of the ten rooms' lights located outside the residents' rooms in those areas did not illuminate when the call bell system was activated. As well, five of the residents' badges did not register to the corresponding pager. [O.Reg 79/10, s.17 (1)(f)]
Staff were unaware in Lodge 2 (Onwatin) that the call bell system was not working when Inspector reported the findings to them. [O.Reg 79/10, s.17 (1)(f)]
On March 1, 2012, the IT resource person reported to Inspector that on February 29, 2012 at approximately 1000 hrs, he became aware of the fact that the call bell system for the Lodge, York and Killarney Units were not functioning. He reported to the Inspector that he was not aware that other areas in the home were experiencing a call bell system malfunction until approximately 1900 hrs. The home is not ensuring that the home is equipped with a resident-staff communication and response system that clearly indicates where the signal is coming from. [O.Reg 79/10, s.17 (1)(f)] (106)
7. On March 1, 2012 at 1450hrs, Inspector 158 checked two residents' bathroom's call bell system in Lodge 2. The lights outside the residents' room did not illuminate.
On March 1, 2012 at 1450hrs, the call bell system in Lodge 2 common room was checked. The lights did not illuminate.

On March 1, 2012, a PSW who worked the evening shift in Lodge 1 on February 29, 2012 identified to Inspector 158 that the call bell system did not work when the PSW rang for assistance to transfer a resident who is a 2-person mechanical lift. PSW identified that a delay of half an hour occurred as no other PSW received the page when the resident's bedside call bell was activated. In addition, the PSW identified that the lights outside the room did not illuminate. The licensee has not ensured that the home is equipped with a resident-staff communication and response system that clearly indicates where the signal is coming from. [O.Reg 79/10, s.17 (1)(f)] (158)

8. The home is not ensuring that the resident-staff communication system (Versus system) clearly indicates where the signal is coming from or that the residents have access to a communication system. The home conducted a planned testing of its generator on February 29, 2012 at 1005hrs. On February 29, 2012, the DOC identified to the Inspectors at 1730hrs that an e-mail was received from the IT resource person indicating that the Versus system was fully operational at 1600h in all areas of the home. The DOC also identified to the Inspectors that manual "silver call bells" were to be in place so that the residents would have access to a communication system.

Ten residents' versus badges and the call bells located in the residents' bathrooms in Tulip, Trillium, Pine, Poplar Units and in Lodge 1 were randomly tested by Inspector on February 29, 2012 at 1330hrs.

It was observed by Inspector that the bathroom call bell light illuminated outside resident's room in Pine Unit, however, the PSW identified that the pager assigned to the resident did not activate. A manual silver call bell was not observed in the resident's room.

A resident was resting in bed when Inspector and a PSW were conducting a test of residents' Versus badges. The light did not illuminate or activate a PSW's pager when the resident's versus badge was pressed. A manual silver bell was not observed within the resident's reach.

A resident's Versus badge illuminated outside the resident's room, however, the Inspector observed that the PSW went to the room located across from the resident's room. The PSW identified to the Inspector that the pager signaled that the page came from the room across the hall from the resident. A silver call bell was not observed within the resident's reach. Inspector and a PSW working on Trillium conducted a test on two residents' badges. The badge did not activate the PSW's pager when pressed. A manual silver call bell was not observed in one of the resident's room. A silver call bell was observed on the dresser located in the other resident's room however, the call bell was not within the resident's reach. Inspector observed that PSWs could not cancel the resident's page in three of the units (Trillium, Pine and Poplar) which were tested.

In Lodge 1, one PSW's pager read "Help - # Block ". The PSW stated, "Where am I to go when it doesn't say?"

The RPN and PSWs on Poplar Unit identified to Inspector on February 29, 2012 that there were not enough working pagers available to all the PSWs working on the day shift. The staff identified that a pager was only available when a scheduled staff member left at 1300h. The staff also identified that a pager was sent for repairs two or three days ago but has yet to return.

Staff who provide care to residents in all Units where the random test of the Versus system was conducted by Inspector reported that communication interruptions with the resident's Versus call for assistance has been an ongoing issue despite the staff's reporting of this issue. The staff identified to Inspector that they have previously reported to management the following: battery failure, lack of available pagers, pager alerts from areas other than the area they are working in, inability to cancel pagers and lack of confidence with the illumination of the light alerts outside resident's rooms.

The home is not ensuring that the home is equipped with a resident-staff communication and response system that clearly indicates where the signal is coming from [O.Reg 79/10, s.17 (1)(f)] and that the home is not ensuring that the home is equipped with a resident-staff communication and response system that was easily seen, accessed and used by residents, staff and visitors at all times. [O.Reg 79/10, s.17(1)(a)] (158) (158)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Apr 27, 2012

Ontario

**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 :** 002

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, 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).

**Order / Ordre :**

The licensee shall ensure that all residents who are at risk of altered skin integrity receive a skin assessment by a member of the registered staff upon any return from hospital, is reassessed by a member of the registered staff at least weekly and that all other requirements pertaining to O. Reg 79/10, s. 50. (2) are complied with. This same non compliance was previously identified in inspection 2011_099188_0035 and CO # 004.

**Grounds / Motifs :**

1. Inspector reviewed the health care record of a resident on March 7, 2012 reviewing the period of February 2012 through March 7, 2012. Inspector noted that the resident has two skin wounds. Inspector noted that an entry in the resident's "Skin Integrity Record" in February 2012 identifies the wounds; however the assessment on the "Wound Assessment Record" for February 2012 was not completed (completely blank, aside from date). Inspector noted the next assessment of these wounds is dated 12 days following the previous entry. Inspector noted that no further assessment of the resident's wound was completed. Only one wound assessment was completed by the registered nursing staff during the four week review period. Inspector spoke with a Registered staff member on March 7, 2012 who confirmed that the resident still has the wounds and continues to receive treatment. The licensee failed to ensure that a resident, exhibiting altered skin integrity, has been reassessed at least weekly by a member of the registered nursing staff. [O.Reg. 79/10, s.50(2)(iv)] (188)
2. Inspector reviewed the health care record of a resident on March 8, 2012. Inspector noted that the resident has a skin wound on the hip. Inspector reviewed the resident's "Wound Assessment Record" and noted that three assessments of the resident's wound were documented between October 2011 and March 2012. Inspector noted that there were no other weekly wound assessments of this resident's wound documented. The licensee failed to ensure that a resident, exhibiting altered skin integrity, has been reassessed at least weekly by a member of the registered nursing staff. [O.Reg. 79/10, s.50(2)(b)(iv)] (188)
3. Inspector reviewed the health care record for three residents who were hospitalized and returned to the home. The inspector did not find a documented skin integrity assessment by registered staff upon return from medical leave for any of the three residents. The licensee failed to ensure a resident, at risk of altered skin integrity, receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital. [O.Reg. 79/10, s.50(2)(a)(ii)] (151)
4. On March 22, 2012 inspector reviewed the health care record for a resident with altered skin integrity who was had been hospitalized and returned to the home. Inspector could not find a skin integrity assessment related to the resident's return from medical leave. Inspector interviewed a Registered staff member regarding the home's process to provide a skin assessment by a member of the registered nursing staff upon return of the resident from hospital. The Registered staff member replied "this was the first I have heard" of the requirement. Inspector then interviewed another Registered staff member regarding the home's process to provide skin integrity assessment by a registered staff upon the return of a resident from hospital. The Registered staff member replied the current practice was for PSW to do the assessment upon the first opportunity presenting; for example morning/bedtime care or next full bath. The licensee failed to ensure a resident, at risk of altered skin integrity, receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital. [O.Reg. 79/10, s.50(2)(a)(ii)] (151)
5. At the time of the inspection, a resident was found to have a skin wound which was being clinically treated. On March 8, 2012, inspector reviewed the resident's "Wound Care Assessment Records". A record of wound assessment was found for January 2012 and two assessments in February 2012. No further assessments were documented. The licensee failed to ensure that a resident with altered skin integrity received at least weekly a skin assessment by a member of the registered staff. [O.Reg.50(2)(a)(iv)] (151)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Mar 30, 2012

## 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

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

Director

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.

Ontario

**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

## 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 23rd day of March, 2012**

**Signature of Inspector / Signature de l'inspecteur :** KSchienbein

**Name of Inspector / Nom de l'inspecteur :** KELLY-JEAN SCHIENBEIN

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

Ontario

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

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

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

**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue**


**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 |
|---|---|---|
| Feb 25, 28, 29, Mar 1, 2, 3, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 18, 19, 22, 23, 2012 | 2012_140158_0005 | Resident Quality Inspection |

**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**

KELLY-JEAN SCHIENBEIN (158), DIANA STENLUND (163), MARGOT BURNS-PROUTY (106), MELISSA CHISHOLM (188), MONIQUE BERGER (151)

**Inspection Summary/Résumé de l'inspection**

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

**During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care (DOC), Program Coordinators, Manager of Administration, Manager of Support Services, Clinical Dietitian, Manager of Food Services (FSS), Administrative Assistant, RAI Coordinator, Manager of Therapeutic Services, Intake and Family Relations Coordinator, Registered Nursing Staff (RN)(RPN), Personal Support Workers (PSW), laundry, housekeeping, dietary and maintenance staff, residents, Resident Council President, families and Family Council President.**

**During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions, care provided to residents, observed meal service, reviewed resident's health care records, reviewed various policies and procedures.**
**The following logs were reviewed as part of this Resident Quality Inspection: S-001309-11, S-001342-11, S-001704-11, S-001705-11, S-001960-11, S-001968-11, S-001983-11, S-001984-11, S-002029-11, S-002111-11, S-002110-11, S-000002-12, S-000060-12, S-000066-12, S-000067-12, S-000068-12, S-000087-12, S-000140-12, S-000154-12, S-000172-12, S-000173-12, S-000174-12, S-000180-12, S-000181-12, S-000224-12.**

**The following Critical Incident Reports were reviewed as part of this Resident Quality Inspection: M566-000032-11, M566-000045-12, M566-000065-11, M566-000066-11, M566-000080-11, M566-000081-11, M566-000083-11, M566-000088-11, M566-000089-11, M566-000005-12, M566-000006-12, M566-000007-12, M566-000009-12, M566-000010-12, M566-000012-12, M566-000013-12, M566-000014-12.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**

**Accommodation Services - Laundry**

**Accommodation Services - Maintenance**

**Admission Process**

**Continence Care and Bowel Management**

**Critical Incident Response**

**Dignity, Choice and Privacy**

**Dining Observation**

**Falls Prevention**

**Family Council**

**Food Quality**

**Hospitalization and Death**

**Infection Prevention and Control**

**Medication**

**Minimizing of Restraining**

**Nutrition and Hydration**

**Pain**

**Personal Support Services**

**Prevention of Abuse, Neglect and Retaliation**

**Quality Improvement**

**Recreation and Social Activities**

**Resident Charges**

**Residents' Council**

**Responsive Behaviours**

**Safe and Secure Home**

**Skin and Wound Care**

**Sufficient Staffing**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON-RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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 O.Reg 79/10, s. 17. Communication and response system**

**Specifically failed to comply with the following subsections:**

**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;**
**(b) is on at all times;**
**(c) allows calls to be cancelled only at the point of activation;**
**(d) is available at each bed, toilet, bath and shower location used by residents;**
**(e) is available in every area accessible by residents;**
**(f) clearly indicates when activated where the signal is coming from; and**
**(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).**

**Findings/Faits saillants :**

1. On March 1, 2012 at 1450hrs, Inspector tested the call bells in two residents' bedrooms in Lodge 2. The lights outside the residents' room did not illuminate.
On March 1, 2012 at 1450hrs, the call bell system in Lodge 2 common room was checked. The lights did not illuminate.
On March 1, 2012, a PSW identified to Inspector that the call bell system did not work when the PSW rang for assistance to transfer a resident who was a 2-person mechanical lift. The PSW identified that a delay of half an hour occurred as no other PSW received the page when the resident's bedside call bell was activated. In addition, the PSW identified that the lights outside the room did not illuminate. The licensee has not ensured that the home is equipped with a resident-staff communication and response system that clearly indicates where the signal is coming from. [O.Reg 79/10, s.17(1)(f)]

2. On February 29, 2012, Inspector checked ten rooms in Killarney, Lilac/Mallard and Park Place Units. Nine of the ten rooms did not have a functioning call bell system in the bathroom that when activated illuminated to the lights outside of the resident's room. The home is not ensuring that the resident call and response system clearly indicates where the signal is coming from.[O.Reg 79/10, s.17(1)(f)]
On February 29, 2012, Inspector checked whether residents who resided in Killarney, Lilac/Mallard and Park Place Units had Versus badges. Three residents residing in these areas did not have a functioning Versus badge. These residents did not have access to a call bell system. [O.Reg 79/10, s.17(1)(a)]

3. On March 1, 2012, Inspector 163 spoke with a PSW who reported that "there are no pagers working on Mallard, it happens probably two times per week". The home is not ensuring that the resident call and response system clearly indicates where the signal is coming from.[O.Reg 79/10, s.17(1)(f)] [O.Reg 79/10, s.17(1)(f)]
On March 1, 2012, Inspector 163 observed a resident who was in a wheel chair on Killarney Unit. Inspector observed that the resident did not have a Versus badge. Inspector 163 asked a PSW if the resident required a Versus badge. The PSW responded, the resident "should have one, it is probably lost in the laundry or something." The resident did not have access to a call and response system. [O.Reg 79/10, s.17(1)(a)]
On March 1, 2012, Inspector 163 tested the call bells in Lilac/Mallard Unit. The call bell did not register on a PSW's pager who was working in that area. The home is not ensuring that the resident call and response system clearly indicates where the signal is coming from. [O.Reg 79/10, s.17(1)(f)]
On March 1, 2012, Inspector 163 tested the call bell in both the shower and tub rooms on Killarney Unit. A PSW working in Killarney indicated to the inspector that the pager was not activated by the test. The home is not ensuring that the resident call and response system clearly indicates where the signal is coming from. [O.Reg 79/10, s.17(1)(f)]

4.The home is not ensuring that the resident-staff communication system (Versus system) clearly indicates where the signal is coming from or that the residents have access to a communication system. The home conducted a planned testing of its generator on February 29, 2012 at 1005hrs. On February 29, 2012, the DOC identified to the Inspectors at 1730hrs that an e-mail was received from the IT resource person indicating that the Versus system was fully operational at 1600h in all areas of the home. The DOC also identified to the Inspectors that manual "silver call bells" were to be in place so that the residents would have access to a communication system.
Ten residents' versus badges and the call bells located in the residents' bathrooms in Tulip, Trillium, Pine, Poplar Units and in Lodge 1 were randomly tested by Inspector on February 29, 2012 at 1330hrs.
It was observed by Inspector that the bathroom call bell light illuminated outside resident's room in Pine Unit, however, the PSW identified that the pager assigned to the resident did not activate. A manual silver call bell was not observed in the resident's room.
A resident was resting in bed when Inspector and a PSW were conducting a test of residents' Versus badges. The light did not illuminate or activate a PSW's pager when the resident's versus badge was pressed. A manual silver bell was not observed within the resident's reach.
A resident's Versus badge when activated illuminated outside the resident's room, however, the Inspector observed that the PSW went to the room located across from the resident's room. The PSW identified to the Inspector that the pager signaled that the page came from the room across the hall from the resident. A silver call bell was not observed within the resident's reach. Inspector and a PSW working on Trillium conducted a test on two residents' badges. The badge did not activate the PSW's pager when pressed. A manual silver call bell was not observed in one of the resident's room. A silver call bell was observed on the dresser located in the other resident's room however, the call bell was not within the resident's reach. Inspector observed that PSWs could not cancel the resident's page in three of the units (Trillium, Pine and Poplar) which were tested.
In Lodge 1, one PSW's pager read "Help - # Block ". The PSW stated, "Where am I to go when it doesn't say."

The Registered staff member and PSWs on Poplar Unit identified to Inspector on February 29, 2012 that there were not enough working pagers available to all the PSWs working on the day shift. The staff identified that a pager was only available when a scheduled staff member left at 1300h. The staff also identified that a pager was sent for repairs two or three days ago but has yet to return.
Staff who provide care to residents in all Units where the random test of the Versus system was conducted by Inspector reported that communication interruptions with the resident's Versus call for assistance has been an ongoing issue despite the staff's reporting of this issue. The staff identified to Inspector that they have previously reported to management the following: battery failure, lack of available pagers, pager alerts from areas other than the area they are working in, inability to cancel pagers and lack of confidence with the illumination of the light alerts outside resident's rooms.
The home is not ensuring that the home is equipped with a resident-staff communication and response system that clearly indicates where the signal is coming from [O.Reg 79/10, s.17 (1)(f)] and that the home is not ensuring that the home is equipped with a resident-staff communication and response system that was easily seen, accessed and used by residents, staff and visitors at all times. [O.Reg 79/10, s.17(1)(a)] (158)

5. On February 29, 2012, Inspector checked ten rooms in Lodge 2, Scenic, Ramsey, Lilac, Mallard and York Units. Eight of the ten rooms' lights located outside the residents' rooms in those areas did not illuminate when the call bell system was activated. As well, five of the residents' badges did not register to the corresponding pager. [O.Reg 79/10, s.17(1)(f)]
Staff were unaware in Lodge 2 (Onwatin) that the call bell system was not working when Inspector reported her findings to them. [O.Reg 79/10, s.17(1)(f)]
On March 1, 2012,the IT resource person reported to Inspector that on February 29, 2012 at approximately 1000 hrs, IT became aware of the fact that the call bell system for the Lodge, York and Killarney Units were not functioning. IT reported to the Inspector that IT was not aware that other areas in the home were experiencing a call bell system malfunction until approximately 1900 hrs. The home is not ensuring that the home is equipped with a resident-staff communication and response system that clearly indicates where the signal is coming from. [O.Reg 79/10, s.17(1)(f)]

6. On March 1, 2012, Inspector spoke with a PSW and a Registered staff member who both stated that they had prior notice from management regarding the planned generator testing and power outage, however, there was no communication that the call bell system was affected until Inspector conducted the testing on the unit February 29, 2012 at 1400hrs. The home is not ensuring that the home is equipped with a resident-staff communication and response system that clearly indicates where the signal is coming from. [O.Reg 79/10, s. 17(1)(f)]

7. The home's resident – staff communication and response system is not easily used by the residents. The home provides two different styles of Versus badges to the residents. The first style is white with an easily pressed button located on its face. The second style is black with a small red rectangular button located on its face which is 0.4 cm by 1.3 cm in size.
On February 29/2012, Inspector 158 and inspector 163 observed that three residents had difficulty pressing the black badge with the small red button without assistance when asked by the inspectors during the testing of the Versus system. [O.Reg 79/10, s.17 (1)(a)]

8. On March 1, 2012 at approximately 1530h, Inspector 163 observed a pager in Lilac Unit's hallway on a care cart. The pager was activated twice within three minutes. There were no staff in the area to hear the pager or address the call. The pager was brought by the inspector to the RPN at the Lilac/Mallard Unit's nursing station.
On March 1/2012 at approximately 1000hrs, a resident on Killarney unit was in a wheel chair outside of the resident's room. Inspector #163 asked a PSW if the resident required a Versus badge. The PSW responded, the resident " should have one, it is probably lost in the laundry or something." [O.Reg 79/10, s.17 (1)(a)]

***Additional Required Actions:***

***CO # - 901 was served on the licensee. 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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

s. 50. (1) The skin and wound care program must, at a minimum, provide for the following:
1. The provision of routine skin care to maintain skin integrity and prevent wounds.
2. Strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents.
3. Strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids.
4. Treatments and interventions, including physiotherapy and nutrition care. O. Reg. 79/10, s. 50 (1).

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. On March 22, 2012 inspector reviewed the health care record for a resident with altered skin integrity who was had been hospitalized and returned to the home. Inspector could not find a skin assessment related to the resident's return from medical leave. Inspector interviewed a Registered staff member regarding the home's process to provide a skin assessment by a member of the registered nursing staff upon return of the resident from hospital. The Registered staff member replied "this was the first I have heard" of the requirement. Inspector then interviewed another Registered staff member regarding the home's process to provide a skin assessment by a registered staff upon the return of a resident from hospital. The Registered staff member replied the current practice was for a PSW to do the assessment upon the first opportunity presenting; for example morning/bedtime care or next full bath. The licensee failed to ensure a resident, at risk of altered skin integrity, receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital. [O.Reg. 79/10, s.50(2)(a)(ii)]
2. Inspector reviewed the health care record for three residents with altered skin integrity and who were hospitalized and returned to the home. The inspector did not find a documented skin assessment by registered staff upon return from medical leave for any of the three residents. The licensee failed to ensure a resident, at risk of altered skin integrity, receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital. [O.Reg. 79/10, s.50(2)(a)(ii)]
3. Inspector reviewed the health care record of a resident on March 8, 2012. Inspector noted that the resident's plan of care identifies that the resident is "prone to redness on buttocks" and an intervention of "Sling is not to be left under the resident following transfers" is included. Inspector observed the resident on March 8 and 12, 2012. Inspector noted during multiple observations throughout both days that the resident was sitting in the wheelchair and a white total lift sling remained under the resident. The licensee failed to ensure that the skin and wound care program provides strategies to reduce and prevent skin breakdown and reduce and relieve pressure. [O.Reg. 79/10, s.50(1)(3)]
4. At the time of the inspection, a resident was found to have a skin wound which was being clinically treated. On March 8, 2012, inspector reviewed the resident's "Wound Care Assessment Records". A record of wound assessment was found for January 2012 and two assessments in February 2012. No further assessments were documented. The licensee failed to ensure that a resident with altered skin integrity received at least weekly a skin assessment by a member of the registered staff. [O.Reg.50(2)(a)(iv)]
5. Inspector reviewed the health care record of a resident on March 8, 2012. Inspector noted that the resident has a skin wound on the hip. Inspector reviewed the resident's "Wound Assessment Record" and noted that three assessments of the resident's wound were documented between October 2011 and March 2012. Inspector noted that there were no other weekly wound assessments of this resident's wound documented. The licensee failed to ensure that a resident, exhibiting altered skin integrity, has been reassessed at least weekly by a member of the registered nursing staff. [O.Reg. 79/10, s.50(2)(b)(iv)]
6. Inspector reviewed the health care record of a resident on March 7, 2012 for the period of February 2012 through to March 7, 2012. Inspector noted that the resident has two skin wounds. Inspector noted that an entry in the resident's "Skin Integrity Record" in February 2012 identifies the wounds; however the assessment on the "Wound Assessment Record" for February 2012 was not completed (completely blank, aside from date). Inspector noted the next assessment of these wounds is dated 12 days following the previous entry. Inspector noted that no further assessment of the resident's wound was completed. Only one wound assessment was completed by the registered nursing staff during the four week review period. Inspector spoke with a Registered staff member on March 7, 2012 who confirmed that the resident still has the wounds and continues to receive treatment. The licensee failed to ensure that a resident, exhibiting altered skin integrity, has been reassessed at least weekly by a member of the registered nursing staff. [O.Reg. 79/10, s.50(2)(iv)]

***Additional Required Actions:***

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

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**WN #3: 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 noted that a resident was transferred to the hospital for assessment at the request of the family. Inspector noted that the resident returned to the home in the families' vehicle following a visit to the emergency room and a discussion between the family, emergency room staff and home's staff. It was communicated to the family by the hospital staff that Pioneer Manor staff would assist the resident from the vehicle upon arrival to the home. Upon arrival to the home the family was informed that staff would not be assisting the resident from the vehicle and that family would need to transfer the resident themselves or return to the hospital to await acceptable transportation. Home staff delivered the resident's wheelchair and a sling to the vehicle but refused to assist the resident from the vehicle. The resident was eventually transferred from the vehicle to the wheelchair by a family member who was contacted to come to the home and transfer the resident. The licensee failed to ensure that the resident was treated with courtesy and respect and in a way that fully recognizes the resident's dignity when the resident was left waiting in a vehicle outside of the home. [LTCHA 2007, S.O. 2007, c.8, s.3(1)(1)]
2. On March 06, 2012 at 0930 hrs, on one Unit, Inspector observed that the doctor (along with two medical students) conducted an assessment on a resident and discussed the resident's personal health information in the middle of the hallway near the nursing station. The licensee failed to ensure that a resident was afforded privacy in treatment and in caring for the resident's personal needs. [LTCHA, 2007,s. 3(1)(8)]
3. On March 6, 2012, Inspector observed a Registered staff member proceed to do a blood glucose test for a resident in the hallway in front of the nursing station. Four other residents were seated in this area. After doing the procedure, the Registered staff member said loudly, "What did you do? Did you have pancakes for breakfast? Did you use your diabetic syrup?". The Registered staff member then proceeded to give the resident the insulin injection. The licensee failed to ensure that every resident has the right to be afforded privacy in treatment and in caring for the resident's personal needs. [LTCHA, 2007, S.O. 2007, c.8, s.3(1)(8)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that all residents are treated with respect and dignity, to be implemented voluntarily.***

**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**
**Specifically failed to comply with the following subsections:**

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

**Findings/Faits saillants :**

1. On March 14, 2012, Inspector observed that the ice machines located in the resident's dining room in Pine, Poplar and Cedar Units had a build up of dust on the outside slats of the upper panel where the air would enter.
The inspector interviewed the housekeeper on one of the units who indicated that the cleaning of the ice machine was done by the Dietary Aide. The Inspector spoke with the Dietary Aide on a different unit who identified that it was the maintenance staff who clean the ice machine. The home did not ensure that the ice machines located in three out of three Units in the home were kept clean and sanitary. [LTCHA 2007, S.O.2007, c.8, s. 15 (2)(a)]
2. On March 12, 2012, staff working in an unit requested Inspector to look at the drain of the "kitchen area" sink. The Inspector observed a build up of soil with green plant shoots growing in the drain. A PSW informed the inspector that at times, this sink is "used to wash and rinse resident dishes". The PSW also identified that plants have been watered and tended to in this sink. The PSW also identified that the staff will clean the sink as needed and inform the housekeeper of additional cleaning requirements. Inspector spoke with the housekeeper who identified that the sink is routinely cleaned on Friday. The home did not ensure that the sink in the unit was clean and sanitary.
The home did not ensure that the home, furnishings and equipment are kept clean and sanitary. [ LTCHA 2007, S.O.2007, c.8, s. 15 (2)(a)]
3. A tour of the home was conducted by Inspector on February 28, 2012. Inspector observed that numerous resident rooms, hallways and common rooms in all units except two required walls painted, gouges in walls plastered, scratched doors resurfaced, missing flooring tiles replaced, base boards to be put up, and uneven surfaces between the hallway flooring and resident bedroom flooring. The home did not ensure that the home, furnishings and equipment are maintained in a safe condition and state of good repair. [ LTCHA 2007, S.O.2007, c.8, s. 15 (2)(c)]
4. On March 7, 8, & 9, 2012, in the Pine, Scenic, Ramsey and York Units, Inspector 106 observed a build up of dirt and debris in corners and near the baseboards in the hallways. On March 7, 8, & 9, 2012, in the Scenic/Ramsey dining room, Inspector observed a dried brown spill was under the hand-sanitizer dispenser that is located near the nursing station. On March 8 and 9, 2012, Inspector observed a dried red spill on the floor near the doors that enter the Scenic home area from the dining room. On March 8 and 9, 2012, in a resident's room, Inspector observed the same crumbs on the floor between an upholstered chair and a small table near the TV. The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary. [LTCHA, 2007, S.O. 2007, c.8, s.15(2)(a)]
5. On March 9, 2012, Inspector observed the couch by the fish tank near the elevator outside Pine Unit to be soiled with a white substance. On March 8, 2012, the fabric belt used for the white sit to stand lift in Scenic Unit was observed by Inspector to be stained with a white substance. On March 7, 2012, Inspector observed the raised toilet seat in a resident's bathroom to have a spot of dried brown material on its surface. On March 7, 8, 9, 2012, the upholstered chair in a resident's was observed to have multiple stains and ground in dirt on the seat, arms and foot rest. The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary. [LTCHA, 2007, S.O. 2007, c.8, s.15(2)(a)]
6. A resident's family member approached Inspector on March 6, 2012 with complaints regarding the cleanliness of the unit where the resident resides. The resident's pillow case was covered with nasal discharge and food debris and was not changed even though it was brought to the attention of the PSW assigned to the resident.
The home did not ensure that the home, furnishings and equipment are kept clean and sanitary. [ LTCHA 2007, S.O.2007, c.8, s. 15 (2)(a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the home is kept clean and sanitary and ensuring that home, furnishings and equipment are maintained in a safe condition and state of good repair, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

**Specifically failed to comply with the following subsections:**

**s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).**

**s. 71. (7) The licensee shall ensure that food and beverages that are appropriate for the residents' diets are accessible to staff and available to residents on a 24-hour basis. O. Reg. 79/10, s. 71 (7).**

**Findings/Faits saillants :**

1. On March 9, 2012, the breakfast meal on one unit was observed by Inspector. The weekly menu posted identified that cream of wheat cereal, poached eggs and hard boiled eggs were to be available. The Dietary Aide identified to Inspector that poached eggs were not available. There was also no 2nd choice for the puree texture diets available.
The home did not ensure that the planned menu items were available and offered to the resident at each meal. [O.Reg. 79/10, s.71(1)(4)].
2. The licensee has not ensured that the planned menu items are offered and available at each meal. In a dining room on March 08, 2012 at lunch, Inspector observed that only one pureed entree choice was available at the meal. This was confirmed by the Dietary Aide present in the dining room. [O.Reg. 79/10, s.71(1)(4)].
3. On March 8, 2012, a resident came to the dining room for breakfast but left as upset related to an agitated resident in the dining room. The resident returned to the dining room at the end of the service but was not provided the breakfast food as the Dietary Aide had thrown out the breakfast food items. The nursing staff requested bread for toast and proceeded to sit the resident at the table, however, the Dietary Aide indicated that the resident could not eat in the dining room as the room needed to be cleaned. The Dietary Aide identified to Inspector that this is the practice and "the rule". The resident was given a banana and toast made by the nursing staff as the kitchen was locked. The home did not ensure that the planned menu items were available and offered to the resident at each meal. [O.Reg. 79/10, s.71(1)(4)].
4. On March 7, 2012, a Registered staff member reported to Inspector 106 that after 1900 hrs, there is no variety of different foods accessible to staff and available to residents. The licensee failed to ensure that food and beverages that are appropriate for the residents' diets are accessible to staff and available to residents on a 24-hour basis. [O. Reg. 79/10, s. 71(7)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring the planned menu items are offered and available at each meal and snack and ensuring food and beverages that are appropriate for the residents' diets are accessible to staff and available to residents on a 24-hour basis, to be implemented voluntarily.***

**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production**

**Specifically failed to comply with the following subsections:**

**s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,**
**(a) preserve taste, nutritive value, appearance and food quality; and**
**(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).**

**Findings/Faits saillants :**

1. On March 14, 2012, Inspector observed the noon meal service on one unit. Inspector observed tray service go out from the dining room and down the hallway to a resident's room. No item on the tray of service was covered for transport to the resident's room. Tray service included: soup, entree, dessert and 2 glasses of fluids. The licensee did not ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and (b) prevent adulteration, contamination and food borne illness.
[O. Reg. 79/10, s.72(3)(a)]
2. Inspector observed that a resident intended to eat in the bedroom with a visitor on March 13, 2012 at 1200hrs. A tray was prepared for the resident by the Dietary Aide and the Inspector observed that the food items were not covered. The resident's visitor was handed the tray and proceeded to deliver the tray to the resident.
The licensee did not ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and (b) prevent adulteration, contamination and food borne illness.
[O. Reg. 79/10, s. 72 (3)(b)].
3. On February 28, 2012, Inspector observed that the various food items served at lunch in an Unit were served in plastic containers and left uncovered on the table from 1215hrs to 1313hrs. Temperature recordings of the food items were done by the Dietary Aide prior to service, however, the home's policy of a second temperature was not taken.
The Inspector observed at 1300hrs that a PSW plated new food items from the above containers for a resident when the resident did not eat the food initially given.
The licensee did not ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and (b) prevent adulteration, contamination and food borne illness.
[O. Reg. 79/10, s. 72 (3)(a)].

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring all foods and fluids in the food production system are prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality; and prevent adulteration, contamination and food borne illness, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

Specifically failed to comply with the following subsections:

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:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. On March 14,2012, Inspector observed the meal service on one unit. Inspector observed the following: a nursing student was providing full meal assistance to a resident. Inspector observed the resident to be seated in a Broda chair reclined at 65-75 degrees. The resident had their chin on their chest and their head tilted to the left. The resident's eyes were closed. At no time during the entire meal service did the student attempt to re-position the resident for safe dining, nor did they attempt to waken the resident before feeding. At no time during the entire meal did any staff attempt to direct the student as to safe positioning and safe technique in the provision of assistance for food and fluid intake for residents.
The licensee failed to ensure that the dining service included proper techniques to assist residents with eating, including safe positioning of residents who require assistance. [O.Reg. 79/10, s.73(1)(10)]
2. On March 9, 2012, Inspector observed that two PSWs on one unit used improper techniques when feeding residents. A resident's plan of care identifies that the resident requires complete feeding by a staff member. A PSW was observed to stand over the resident at an angle while the feeding them. Another PSW was also observed by the inspector to stand and tower over a resident when feeding the resident. The resident's plan of care identified that the resident requires complete feeding by a staff member.
The licensee failed to ensure that the dining service included proper techniques to assist residents with eating, including safe positioning of residents who require assistance. [O.Reg. 79/10, s.73(1)(10)]
3. On February 28, 2012, during a meal service in an Unit, Inspector observed that the weekly menu that was posted was for week 3. The daily menu that was posted was for week 1. The food that was served for lunch was in accordance with the posted week 1 daily menu. The Licensee failed to ensure that the home has a dining and snack service that includes communication of the seven-day and daily menu to residents. [O. Reg. 79/10, s.73(1)(1)]
4. On February 28, 2012, the dining service on one unit was observed by Inspector. As there was only one of the two regularly scheduled Dietary Aides working on this date, the dining service did not start until 1215hrs and not 1200hrs. Initially, there was one PSW present in the dining room. Another PSW arrived at 1225hrs. The Inspector observed that both the PSWs questioned each other as to the needs of the residents. Both PSWs identified that they were not familiar with the residents and their needs when questioned by the inspector. At no time did the Inspector observe any staff to reference the dietary list which was opened on the island located near the table. The Inspector observed that when there was only one of the PSWs present in the dining room, the PSW retrieved the plated meal from the Dietary Aide for a resident. The PSW placed the meal in front of that resident, then proceeded to serve and feed another resident. The inspector observed that the dietary list identified that the resident whose meal was placed in front of them required total assistance to eat. It was only after the arrival of the other PSW at 1225hrs that the resident was provided total assistance to eat. The resident who required assistance with eating and drinking was not served a meal when someone was available to provide them this assistance.
The licensee did not ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.
[O.Reg. 79/10, s.73(2)(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 ensuring that the dining service includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance and ensuring that no resident who requires total assistance to eat is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.***

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**WN #8: 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. (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. The licensee has not ensured that the home's documentation includes consent for the use of a physical device to restrain a resident. On March 08, 2012, Inspector reviewed the plan of care for a resident. The plan of care indicates that two partial side rails are to be used when in bed due to high risk for falls and that the resident is totally dependent on staff for all bed mobility. Inspector reviewed the resident's health care documentation on March 08, 2012. There was no consent for the use of the two partial bedside rails which are used as a physical device to restrain the resident. [O.Reg. 79/10,s. 110 (7)4]
2. The licensee has not ensured that the home's documentation includes monitoring of a physical device to restrain a resident. The plan of care for a resident indicates that two partial side rails are used when in bed due to high risk for falls and that the resident is totally dependent on staff for for all bed mobility. Inspector interviewed a Registered staff member on March 08, 2012 regarding this resident and the monitoring of the two partial side rails. The Registered staff member reported "there is no monitoring for these rails." Inspector along with the Registered staff member reviewed the health care documentation for the resident. There was no monitoring documentation in the health care record for the resident. [O.Reg. 79/10,s. 110 (7)6]

***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 requirements relating to restraining by a physical device are met, to be implemented voluntarily.***

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**WN #9: 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 :**

1. The licensee has failed to 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: 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. Inspector interviewed the Manager of Therapeutic Services on March 09, 2012. The Manager reported "I do not have any formal evaluation of the volunteer and recreation activities programs completed." Reg. 79/10, s. 30 (3)].
2. The licensee has not ensured that for each program required under sections 8 to 16 of the Act and section 48 of the Regulation, that there is a written description of the program that includes 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. On March 09, 2012, Inspector interviewed the Manager of Therapeutic Services regarding general requirements for programming. The Manager reported "I have not formalized the volunteer and activities programs yet with respect to writing up goals and objectives etc." [O.Reg.79/10,s.30(1)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 ensuring that a description of the program that includes 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 is written and ensuring the program is evaluated and updated at least annually, to be implemented voluntarily.***

**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**
**Specifically failed to comply with the following subsections:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:**
**1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.**
**2. Residents must be offered immunization against influenza at the appropriate time each year.**
**3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.**
**4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.**
**5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).**

**Findings/Faits saillants :**

1. Inspector observed a Registered staff member during the medication pass on March 12, 2012. The Registered staff member did not wash their hands between residents as the Registered staff member administered medication. The licensee failed to ensure staff participate in the implementation of the infection prevention and control program. [O.Reg. 79/10, s.229(4)]
2. On March 12, 2012, Inspector observed that a Registered staff member who was administering medications to residents did not wash their hands between residents. The inspector observed that a Registered staff member's hands touched a resident's mouth as the Registered staff member assisted the resident to drink. The Registered staff member proceeded to administer another resident's insulin and did not wash their hands. The licensee failed to ensure staff participate in the implementation of the infection prevention and control program. [O.Reg. 79/10, s.229(4)]
3. On March 07, 2012, the home's Infection Control Coordinator identified to Inspector that Tetanus/Diptheria immunization (tdp) has not been offered to the residents. The Infection Control Coordinator identified that the home is currently working on a policy and that the Public Health Unit will release the immunization when the policy is approved. The home failed to offer residents immunizations against diptheria and tetanus. [O.Reg. 79/10, s.229(10)3]
4. The health records of two residents who were admitted after July 2010 were reviewed by Inspector on March 7, 2012. There was no documentation found identifying that a TB test was given. The home failed to ensure that each resident admitted to the home be screened for tuberculosis (TB) within 14 days of admission. [O.Reg. 79/10, s.229(10)1]
5. On March 8, 2012 during a medication pass, the Inspector observed a Registered staff member administer nose spray and eye drops to a resident. The RPN did not practice hand hygiene before administering medications to the next resident. The licensee failed to ensure that all staff participate in the implementation of the Infection Prevention and Control Program. [O. Reg. 79/10, s.229(4)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that all staff participate in the implementation of the infection prevention and control program, that the home screen for tuberculosis within 14 days of admission and that residents are offered immunization against tetanus and diptheria, to be implemented voluntarily.***

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**WN #11: 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).**

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**Findings/Faits saillants :**

1. On March 13, 2012, a resident was observed by Inspector seated in a wheel chair with a front buckling seat belt. The PSW identified to the inspector on March 13, 2012 that the resident would not be able to undo the seat belt. The resident's health care record was reviewed by Inspector on March 13, 2012. There is an order for the restraint and a consent, however, the health care record did not contain an assessment of the alternatives to restraining that were considered and tried and found not effective in addressing the resident's need. The licensee did not ensure that the restraining of a resident by a physical device could be included in a resident's plan of care only if alternatives to restraining the resident have been considered, tried and found to be, or have not been, effective to address the risk. [LTCHA, 2007, S.O. 2007, c.8, s.31(2)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 restraining of a resident by a physical device is included in a resident's plan of care only if alternatives to restraining the resident have been considered, tried and found to be, or have not been, effective to address the risk, to be implemented voluntarily.***

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**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system**

**Specifically failed to comply with the following subsections:**

**s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).**

**s. 114. (3) The written policies and protocols must be,**
**(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and**
**(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).**

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**Findings/Faits saillants :**

1. On March 12, 2012, a Registered staff member was observed by Inspector to leave a resident's medication at the table while the resident ate. The Registered staff member did not stay with the resident to ensure that the resident took all the medication. The licensee has not ensured that the written policies and protocols for medication administration were developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [O.Reg. 79/10, s.114(3)(a)]
2. The medication pass by a Registered staff member was observed by Inspector on March 12, 2012. The Registered staff member was observed to administer insulin to two residents. The Registered staff member identified to the Inspector that one of the residents receiving insulin requests that the insulin be administered at the same site. During the administration of the resident's insulin, the resident's arm was observed by the Inspector to have a multitude of red puncture marks.
The Registered staff member identified to the Inspector that the other resident requests the insulin be given in the abdomen. The abdomen was observed by Inspector to have more puncture marks on the right side of the abdomen than on the left. The Registered staff member identified to the Inspector that both residents' insulin are injected in the same area. The Inspector inquired as to the home's process of insulin administration and site rotation.
The Registered staff member identified to the Inspector that the One-Mar system has a process for site rotation but the process is not followed.
A written policy to direct the insulin administration and rotation of sites was not found by the Inspector. The licensee has not ensured that written policies and protocols are developed for the medication management system to ensure the accurate administration of all drugs used in the home. [O.Reg. 79/10, s.114(2)]
3. On March 9, 2012, Inspector observed a medication administration pass. Inspector observed the Registered staff member inject a resident with insulin in the arm. Inspector inquired as to the home's process to ensure that insulin injections followed a process of site rotation. The Registered staff member replied that a process was built into the One-Mar System, and "honestly, no one does it". When asked why it was that staff did not follow the site rotation system in One-MAR, the Registered staff member replied "staff will say it is because they have no time to do it". Inspector reviewed the home's policy and procedure manuals for a policy to direct staff on the administration of insulin and the need for rotation of injection sites. None was found. The licensee has not ensured that written policies and protocols are developed for the medication management system to ensure the accurate administration of all drugs used in the home. [O.Reg. 79/10, s.114(2)]
4. On March 13, 2012, Inspector observed a PSW report to the Registered staff member that a resident did not take all the breakfast pills, which were left in the medicine container near the place setting on the dining room table. The Registered staff member was observed by the Inspector to retrieve the medication from the table and give the medication to the resident who then was portered to the bedroom via w/c by the PSW. The Inspector reviewed the resident's health care record and it identified that the resident has moderate cognitive impairment. The Registered staff member stated to the Inspector that it is the resident's request to take medication with meals. The Registered staff member indicated that there are other residents who also make this request. The Registered staff member further added that the resident's medication will be left with them as the Registered staff member "does not have time to stay and watch them take their pills". The licensee has not ensured that the written policies and protocols for medication administration were developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [O.Reg. 79/10, s.114(3)(a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring written policies and protocols are developed for the administration of insulin with site rotation and that the home's written policy and prevailing practices are implemented when medication is administered in the home, to be implemented voluntarily.***

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**WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following subsections:**

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

**Findings/Faits saillants :**

1. A resident receives a benzodiazapine, which is a controlled substance. Inspector observed that the resident's medication was stored in the medication cart in the strip packages along with the rest of the resident's regularly scheduled medication. The benzodiazapine was not stored in a separate locked area within the locked medication cart. The licensee did not ensure that a controlled substance as defined in the LTCHA and in the Controlled Drug and Substance Act was stored in a separate, double-locked stationary cupboard in the locked area or in a separate locked area within the locked medication cart. [O.Reg. 79/10, s.129(1)(b)]
2. It was observed by Inspector on March 7, 2012 that three of a resident's prescribed creams were in a travel bag located in the bathroom. One of the creams was expired. Directions for self use was identified on one of the three creams. The resident's plan of care identifies that the resident requires extensive assistance of staff for hygienic care. The Program Coordinator confirmed that the resident would not be able to apply the cream themself when the inspector gave the Program Coordinator the creams found in the resident's bathroom on March 7, 2012. The licensee did not store the resident's prescribed creams in a area or medication cart, that is exclusively for drugs and drug related supplies, that is secured and locked, or that protects the drugs from heat, light, humidity or other environmental conditions. [O.Reg. 79/10, s.129(1)(b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring drugs are stored in an area or a medication cart that is secure and locked and that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area, to be implemented voluntarily.***

**WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing**

**Specifically failed to comply with the following subsections:**

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

**Findings/Faits saillants :**

1. On March 8, 2012, the Inspector reviewed three resident's flow sheets from December 2011 to March 8, 2012.
According to a resident's plan of care, the resident is to receive a bath two days a week.
Week 1 flow sheets identify the resident did not receive their preferred bath as the unit was short staffed on the resident's scheduled bath day. A second bath was not documented as having occurred for week 1.
The flow sheets identify that the resident received only 1 bath for week 2. A second bath was not documented as having occurred.
The flow sheets identify that the resident received only 1 bath for week 3. A second bath was not documented as having occurred.
The flow sheets identify that the resident received only 1 bath for week 5. A second bath was not documented as having occurred.
The resident identified to the Inspector on March 9, 2012 that it is upsetting that they do not always receive two baths a week and that the choice of a bath is not always provided.

A resident's plan of care identifies that the resident is scheduled to have a shower two days a week. The Inspector detected a body odour from the resident on March 9/12.
Week 1 flow sheets identify that on the resident's bath day the unit was short staffed. The resident did not have any documented baths/showers for that week.
Week 2 flow sheets identify that the resident received a bed bath and not the preferred choice of bath on the resident's scheduled bath day as the unit was short staffed. A second bath/shower was not documented as having occurred.
Week 5 flow sheets identify that the resident did not have any documented baths/showers for that week.
Week 6 flow sheets identified that the resident received a shower, however, a second bath/shower was not documented as having occurred.
Week 7 flow sheets identified that on the resident's bath day the unit was short staffed. A bath/shower was not documented as having occurred. The resident identified to the inspector that they do not always receive two showers a week.

A resident's plan of care identifies that their tub bath is scheduled two days a week.
The resident stated to the inspector on March 8, 2012 that they did not have any baths last week. The resident also indicated that this is upsetting.
Week 4 flow sheets identify that the resident received a tub bath, however, a second bath was not documented as having occurred.
Week 5 flow sheets identified that the resident received a bath, however, a second bath was not documented as having occurred.
Week 7 flow sheets identified that the resident did not receive a bath on their scheduled bath day as the unit was short staffed.
Three out of three residents of the home were not bathed, at a minimum, twice a week by the method of his or her choice. The licensee did not ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.
[O.Reg. 79/10, s.33(1)]

***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 each resident is bathed, at a minimum, twice a week by the method of his or her choice, to be implemented voluntarily.***

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**WN #15: 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).**

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**Findings/Faits saillants :**

1. A resident's annual MDS assessment identified the resident as being incontinent of urine and bowel and requiring the use of an incontinent product. The resident's health care record was reviewed by Inspector on March 13, 2012. A continence care assessment was not found in Point Click Care or in the resident's health care record. There is no reference to an assessment in the progress notes. A bedside assessment tool was completed for the observation period of the MDS assessment, however, this bedside assessment does not reference continence. Inspector interviewed a Registered staff member on March 13, 2012 who stated that continence assessments are done in Point Click Care. The paper copy of the continence assessments are no longer completed. The Inspector spoke with the RAI Coordinator on March 14, 2012 who identified that the continence assessments are now completed on Point Click Care. The home did not ensure that a resident who is incontinent received an assessment using a clinically approved assessment tool that is specifically designed for assessment of incontinence.
[O.Reg. 79/10, s.51(2)(a)]
2. Inspector reviewed the health care record of a resident on March 13, 2012. Inspector noted that the MDS and plan of care identify that the resident is incontinent. Inspector spoke with two PSWs who confirmed that the resident is incontinent of urine. Inspector reviewed the assessments completed for the resident and noted that no continence assessment has been completed. Inspector spoke with a Registered staff member who confirmed that no continence assessment has been completed. The Registered staff member identified it should be completed during the quarterly along with the MDS and other assessments that are completed on an quarterly basis. The licensee failed to ensure the resident who in incontinent received an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [O.Reg. 79/10, s.51(2)(a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring each resident who is incontinent receives an assessment using a clinically appropriate assessment instrument, to be implemented voluntarily.***

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**WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following subsections:**

**s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:**
**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 any 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. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident 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 who made the initial report to the Director under subsection (1) or (3), 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. 107 (4).**

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**Findings/Faits saillants :**

1. Inspector reviewed a critical incident report on March 13, 2012. Inspector noted the section for long-term action identified "these actions will be identified when all information has been gathered from the investigation". The critical incident report was never amended to include long-term actions. Inspector spoke with the Program Coordinator on March 13, 2012 who confirmed that the critical incident report had not been updated to include the required long-term actions. The licensee failed to ensure the written report includes analysis and follow-up including the long-term action planned to correct the situations and prevent recurrence. [O.Reg. 79/10, s.107(4)(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 critical incident reports submitted to the Director contain long-term actions planned to correct the situation and prevent recurrence, to be implemented voluntarily.***

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**WN #17: 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. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,**
**(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals;**
**(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and**
**(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).**

**Findings/Faits saillants :**

1. The home's policy titled:MEDICATION- PRESCRIPTION CREAM TOPICAL APPLICATION - last revised June 5, 2010 states "Topical prescription creams may be applied by a Health Care Aide (HCA) if the procedure had been taught, assigned and supervised by the Home Area registered nursing staff".
Inspector interviewed two PSWs on March 9, 2012. Both staff members stated that they do apply topical creams and ointments as directed by the registered staff. Both staff confirmed that they have not received any training in the application of topical medications, "it is just expected we do it".
Review of the home's orientation package for new staff shows that the educational content does not include the application of topical creams or ointment. Review of the annual staff development package shows that the content does not include review of the application of topical creams or ointments.
Random audit of resident rooms on March 13, 2012 shows that Inspector found 5 of 20 resident rooms (20%) had prescription cream, ointment, nasal sprays or eye drops at the bedside and not in the control of the registered staff.
The licensee has not ensured that a member of the registered nursing staff permits a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical only if: the staff member has been trained by a member of the registered nursing staff in the administration of topicals; the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. [O.Reg. 79/10, s.131 (4)]

**WN #18: 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 progress notes for a resident who was making sexually inappropriate comments.
Review of the resident's current plan of care shows that it does not address this sexually inappropriate behaviour.
Inspector reviewed the progress notes with a Registered staff member on March 12, 2012. The Registered staff member stated that given the documentation, the care plan should be addressing the behaviour of sexual inappropriateness.
In an interview with Manager of Resident Care on March 12, 2012, the Manager confirmed that the home does not have a formal responsive behaviour program.
The licensee failed to ensure that there are written approaches to care developed to meet the needs of the residents with responsive behaviours. [O.Reg. 79/10, s.53(1)(1)]

There are additional findings related to Responsive Behaviours specifically [O. Reg. 79/10, s. 53 (4)] issued in inspection 2012_140158_0002, CO-003.

***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 written approaches to care are developed to meet the needs of all residents with responsive behaviour, to be implemented voluntarily.***

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**WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs**

**Specifically failed to comply with the following subsections:**

**s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,**
**(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;**
**(b) the identification of any risks related to nutrition care and dietary services and hydration;**
**(c) the implementation of interventions to mitigate and manage those risks;**
**(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and**
**(e) a weight monitoring system to measure and record with respect to each resident,**
**(i) weight on admission and monthly thereafter, and**
**(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).**

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**Findings/Faits saillants :**

1. Inspector reviewed the health care record of a resident on March 9, 2012. Inspector noted the resident experienced a weight loss from November 2011 to January 9, 2012. Inspector noted there was no December 2011 weight. The home's policy in relation to weight loss directs staff to re-weigh a resident when it is noted that a resident experienced a "significant weight loss or gain" from the previous result. Inspector interviewed the Food Services Manager, on March 9, 2012. The Food Service Manager identified that 2.0kg deviation suffices for a re-weigh. Inspector could not locate in the resident's health care record or on the home's "monthly weight" clipboard any re-weigh value. In addition, it is noted in the resident's health care record that the resident was transferred to another unit. The resident was not added to the new unit's resident "monthly weight" clipboard until March 9, 2012 when Inspector asked staff to assist in finding the resident's February weight. Staff confirmed that the resident had not been weighed for February 2012. The licensee failed to ensure policies and procedures related to nutrition care and hydration were implemented. [O.Reg. 79/10, s.68(2)(a)]

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**WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.**

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**Findings/Faits saillants :**

1.On March 13, 2012, Inspector observed that a resident's privacy curtain did not completely close. (The resident shares the room with another resident). The curtain itself would provide complete privacy, however, the grommets have become entangled with the mesh of the curtain and does not allow for the complete closure or privacy when the curtain is pulled. This situation remained unchanged from when it was first observed on March 1, 2012 to March 13, 2012.
Inspector observed on March 14, 2012 that a resident's privacy curtain was not completely pulled closed when the PSW was providing personal care. The Inspector observed that the grommets were not connected to the curtain's edge causing the curtain to fall and not provide complete privacy.
Another resident's privacy curtain did not provide complete privacy related to the entanglement of the mesh part of the curtain and the grommets. (The resident shares the room with another resident). A PSW identified to the Inspector that there are several privacy curtains on the Unit which are caught and do not provide complete privacy. A PSW confirmed that a PSW or a Registered staff member can enter a work order into maintenance to have the curtains fixed. A PSW identified that a work order was placed 2 weeks ago to address the ill placed privacy curtain in the resident's room, however, as of March 14, 2012, the curtain remains the same. The privacy curtains in three out of three residents' rooms do not provide sufficient privacy. The licensee did not ensure that each resident bedroom occupied by more than one resident have sufficient privacy curtains to provide privacy. [O.Reg. 79/10, s.13]

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**WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services**

**Specifically failed to comply with the following subsections:**

**s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,**
**(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and**
**(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).**

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**Findings/Faits saillants :**

1. On March 12, 2012, and in the absence of vacationing Manager of Support Services, Inspector spoke to the Manager of Laundry. The Manager of Laundry identified that a process to paint residents' rooms is in place, however, there is no scheduled remedial painting program for the residents' rooms. The icensee did not ensure that there are schedules and procedures in place for routine, preventive and remedial maintenance. [O.Reg. 79/10, s.90(1)(b)]

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**WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.**

**Specifically failed to comply with the following subsections:**

**s. 29. (1) Every licensee of a long-term care home,**
**(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and**
**(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).**

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**Findings/Faits saillants :**

1. The licensee has not ensured that their written policy to minimize the restraining of residents is complied with. The homes policy titled "Restraint Use (Least Restraint)" indicates "Physical Restraints: are physical devices or mechanical devices that are used to intentionally prevent the movement of the whole or a portion of a resident's body in order to control the resident's physical activity.
On March 08, 2012, Inspector observed two partial bed rails in the up position for a resident on one unit. Inspector interviewed the Registered staff member on March 08, 2012 who reported that the resident uses two partial rails "to protect from falls". The resident's plan of care indicated that the resident is at high risk for falls/injury due to increased weakness, and confusion and that two partial side rails are required when in bed. The plan of care also states "total dependence on staff for all bed mobility. The resident no longer mobilizes. Remains in bed." The home did not identify that the use of bed rails for the resident was a restraint as the rails prevented the movement of the resident's body and controlled the resident's activity.[2007, c.8,s.29(1)(b)]

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**WN #23: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**s. 6. (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).**

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**Findings/Faits saillants :**

1. These are additional findings of Non-Compliance for previously issued CO-001 and CO- 002, from inspection 2012_140158_0002 which must be complied with by March 23, 2012.
2. A resident's plan of care was reviewed by inspector on March 13, 2012. The resident's plan of care identifies that the resident is "independent with transferring and toileting". A Fall risk problem identifies such interventions as ensure the room is free of clutter, ensure the resident wears proper foot wear and ensure the Versus badge is clipped to clothing at all times. The Inspector observed on March 9, 2012 and on March 13, 2012 that the resident did not have a Versus badge clipped to the clothing. The resident's room was observed to be cluttered with personal articles and the shoes that were worn were loose and not securely closed. The licensee did not ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007, S.O. 2007, c.8, s.6(7)]
3. Inspector reviewed the plan of care for a resident related to sleep rest pattern on March 7, 2012. Inspector noted that the "bedside kardex report" and "care plan" identified, the resident " as per family request is to be returned to bed after breakfast and after lunch if not attending programs". Inspector noted a separate printed undated page titled "Routine" which identifies "family willing to work with a later morning to get up and then to go to bed right away after lunch". This is unclear direction related to the resident and the sleep routine following breakfast. Inspector observed a PSW and a Registered staff member review the plan of care on March 7, 2012 and were unable to determine which action to follow. Inspector spoke with the resident's family on March 8, 2012, who identified that currently the resident is staying in bed later in the morning and returning to bed after lunch. The licensee failed to ensure that the plan of care provide clear direction to staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c.8, s.6(1)(c)]
4. Inspector reviewed the health care record for a resident on March 7, 2012. Inspector noted that the plan of care related to fluid and hydration provided conflicting and unclear direction. Inspector noted that one section identifies the resident is on a fluid restriction of 2000mls daily. A section titled "fluid output" identifies the resident is on a fluid restriction of 1500mls daily. Inspector reviewed the diet list in the dining room on March 12, 2012. Inspector noted it identifies a fluid restriction of 500mls at breakfast and 250mls each at lunch and supper (totaling 1000mls/day), it does not provide any other direction related to the resident's daily fluid restriction or total daily fluid restriction. Inspector reviewed the snack diet list found on the snack cart on March 12, 2012. Inspector noted that under PM and HS snack it says 250mls fluid only, it does not provide any other direction related to the resident's daily fluid restriction of total daily fluid restriction. Inspector reviewed the resident's assessment completed by the dietitian and noted the resident should be on a fluid restriction of 2000mls a day. Inspector spoke with a Registered staff member and PSW on the unit on March 12, 2012. They confirmed the resident was on a fluid restricted diet but were unable to identify what total daily amount is currently being followed. The licensee failed to ensure that the plan of care sets out clear directions for the staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c.8, s.6(1)(c)]
5. A resident's plan of care was reviewed by Inspector on March 8, 2012. A Fall risk problem identifies such interventions as ensure the room is free of clutter, ensure the Versus badge is affixed to the chair and that the resident has access to the badge at all times and the height of the bed is at the lowest position during transfers. The resident's Versus badge was missing from Feb 28, 2012 until March 9, 2012. The resident did not have the badge affixed to the chair as per the care plan or have access to it.
The resident's bed was observed by Inspector to remain in a high position when the one staff transferred the resident into a wheel chair.
Crackers and other food items were observed by Inspector to be stored on the bedroom window ledge and out of reach. On March 8, 2012, the resident was observed by the Inspector to be standing in attempts to reach for the crackers which were out of reach. The resident's room was littered with boxes, paper, food and remotes on the floor on Feb 28, 2012 and from March 1 to March 6, 2012. The licensee did not ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007, S.O. 2007, c.8, s.6(7)]
6. A resident's plan of care identifies that the resident is incontinent of urine and is to be toileted q2hr while awake and as required (prn). On March 7, 8, and 9, 2012, the Inspector did not observe the resident to be toileted q2h as per the plan of care. The licensee did not ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007, S.O. 2007, c.8, s.6(7)]
7. A resident's health care record was reviewed by the Inspector on March 9, 2012 and the dietitian's notation of the possible addition of a nutritional supplement was found. The dietician made reference that this would be discussed with the resident. The resident's cognition assessment identified the resident as moderately impaired. The resident's physician notes were reviewed by the Inspector and there is no order for a supplement. Inspector interviewed a Registered staff member and PSWs on March 9, 2012 who identified they were not aware of any plans to include a supplement to the resident's diet.
The licensee did not ensure that the staff and others involved in the different aspects of care of the resident collaborate

with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.
[LTCHA 2007, S.O. 2007, c.8, s.6(4)(b)]
8. A resident's plan of care identified that the resident requires complete feeding by one staff as the resident falls asleep during the meal. Inspector observed on March 9, 2012 that a plate of toast was placed in front of the resident by the Dietary Aide at 0920hrs. There was no assistance provided to the resident until 0950hrs when a PSW was in the dining room. The resident was observed by the inspector to fall asleep during this period.
A resident's plan of care identified that the resident requires sporatic physical assistance and supervision with eating by one staff as the resident refuses to be fed. Inspector observed on March 9, 2012 that a plate of toast was placed in front of the resident by the Dietary Aide. There was no assistance or supervision provided to the resident. The resident was observed by the Inspector to eat two bites and then fall asleep during this period.
On March 9, 2012, Inspector observed a resident in the dining room eating breakfast slowly. The resident's plan of care identified that the resident requires intermittent encouragement and supervision by one staff. Inspector did not observe that intermittent encouragement or supervision was provided to the resident. The licensee did not ensure that the care set out in the plan of care is provided to the resident as specified in the plan.[LTCHA 2007, S.O. 2007, c.8, s.6(7)]
9. Inspector reviewed the plan of care for a resident on March 8, 2012. The plan of care gives conflicting and unclear direction to staff providing care. In regards to MOBILITY, the plan of care states for the "focus" section, "requires no assistance for MOBILITY." In the corresponding "Interventions" section, the plan of care states "extensive assistance required". The licensee failed to ensure that the plan of care sets out clear directions for the staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c.8, s.6(1)(c)]
10. The plan of care for a resident indicated, "Daily cleaning of teeth/dentures and daily mouth care done by staff". A Registered staff member and a PSW that provide care for the resident were interviewed and both stated that the resident refuses oral care assistance. The plan of care does not indicate what staff members are to do if the resident refuses assistance with oral care. The licensee failed to ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident. [LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(c)]
11. Inspector reviewed the plan of care for a resident on March 8, 2012. The plan of care gives conflicting and unclear direction to staff providing care. In the "Focus" section of the plan of care, it is identified the resident "requires no assistance for TRANSFERRING". In the corresponding "Interventions" section, the direction is that "one staff is required to set up walker ". The licensee failed to ensure that the plan of care sets out clear directions for the staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c.8, s.6(1)(c)]
12. A resident's plan of care was reviewed by Inspector on March 7, 2012. Under Activity, interventions such as encourage resident to talk of the past experiences, encourage resident to participate in Exercise group, attend music group, encourage resident to attend bocce and bean bag toss were identified. The activity calender posted at the nurses desk identified on this date, March 7, 2012 that fun and fitness was scheduled at 1030hrs and bocce was scheduled for 1330-1500hrs. Exercises were conducted in the activity room on March 8, 2012. Bocce was conducted at 1330pm. The resident remained in the resident's bedroom room and was not portered to any activity or attend any activity. The licensee did not ensure that the care set out in the plan of care is provided to the resident as specified in the plan.
[LTCHA 2007, S.O. 2007, c.8, s.6(7)]

**Issued on this 17th day of April, 2012**

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