Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 7, 2015	2015_281542_0017	018934-15	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

PRINCESS COURT
PRINCESS STREET BOX 725 DRYDEN ON P8N 2Z4

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

JENNIFER LAURICELLA (542), DEBBIE WARPULA (577), LAUREN TENHUNEN (196), SHEILA CLARK (617)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 31, 2015 and September 1, 2, 3, 4, 8, 9, 10, 11, 2015.

The following Logs were inspected concurrently with the Resident Quality Inspection:
Log # 12568-15, 2858-14, 4909-14, 8380-14, 4617-15, 6296-15 and 24430-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care (s), Registered Staff, RAI Coordinator, Personal Support Workers (PSWs), Maintenance Staff, Dietary Staff, Recreational Therapy Staff, Housekeeping Staff, Residents and Family Members.

The Inspectors reviewed various policies and procedures, health care records, employee files, conducted daily walk through of the resident care areas, observed staff to resident interactions and the provision of care to residents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 101. (1)	CO #001	2014_333577_0019	577

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

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:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraints for resident #004, #005, #025, #026, #027, #028, #029 and #030 and #047 were applied in accordance with the manufacturer's instructions.

On August 31, 2015, Inspector #542 observed resident #026 in their wheel chair with a restraint on. The restraint ends were wrapped around the outside of the wheel chair sides and then secured to the back of the wheel chair, instead of around the resident and then secured to the back. The restraint was noted to be very loose and not secured properly. Inspector #542 immediately spoke with S#100 who agreed that the restraint was not applied correctly and that it was ill fitting. S#100 re-applied the restraint correctly for this resident at that time.

On September 2, 2015, Inspector #577 observed resident #004 to be sitting in their wheelchair with a applied to outer sides of wheelchair. The restraint was observed to be very loose in front of the resident.

On September 3, 2015, Inspector #577 observed residents #047, #025 and #029 to be sitting in their wheelchairs with restraints on and applied to the outer sides of the wheelchair. A short time later, resident #047 remained up in their wheelchair and the Director of Care (DOC) was on the unit. Inspector #577 spoke with the DOC and asked about the application the restraints in a wheelchair. The DOC confirmed that the restraint used by resident #047 was incorrectly applied to the outside of the wheelchair. Inspector

observed the DOC secure the restraint around the resident and to the inside of the wheelchair, securing it at the back of the wheelchair. Later that same day, Inspector again observed residents #004, #030, #029, #028 and #025 to be up in their wheelchairs with a restraint on and applied to the outsides of their wheelchairs.

On September 3, 2015, Inspector #542 observed resident #025 in their wheel chair with a restraint in place. The restraint was wrapped around the wheel chair sides instead of around the resident, and this restraint was also too loose for the resident. Inspector #542 spoke to S#101 who verified that the restraint was too loose.

On September 4, 2015, Inspector #577 toured a specific home area with the DOC and observed residents #004, #025, #028 and #047 sitting in their wheelchairs with their restraints attached to the outside of their wheelchairs. The DOC further confirmed that the restraints were applied incorrectly.

Inspector #577 received the manufacturer's instructions for the application of restraints from the DOC. The instructions indicated "bring the ends of the connecting straps on the narrow end, down between the seat and the wheelchair sides. Secure the straps behind the backrest. Bring the ends of the connecting straps on the wide end, down between the seat and wheelchair sides at a 45 degree angle. Secure the straps behind the backrest as low as possible. Check that the straps are secure and will not change position, loosen, or tighten if the resident pulls on them, or if the chair is tilted or adjusted". The picture illustrated that the straps are secured between the seat and wheelchair sides.

On September 9, 2015, Inspector #577 spoke with the DOC who indicated that the Assistant Director of Care (ADOC) trains the staff on restraints and that they did not teach them to apply the restraints on the outside of the wheel chair.

On September 10, 2015, Inspector #196 observed resident's #026, #005, #027 and #028 all with a restraint incorrectly applied. Inspector #542 and #196 proceeded to inform the Administrator and the ADOC. The ADOC agreed that the restraints were applied incorrectly. [s. 110. (1) 1.]

2. The licensee has failed to ensure that the restraint documentation for resident #021 included every release of the device and repositioning.

On September 3, 2015, Inspector #542 observed resident #021 in their wheel chair, in a tilted position with a table top on that was secured at the back of the wheel chair.

Resident was also noted to have another restraint on as well. The most recent care plan accessible to the direct care staff identified that the Health Care Aides were to perform safety checks hourly and this was to be documented on the Restraint Monitoring Form.

Inspector #542 reviewed the home's policy titled, "Restraints - Minimizing Use of Restraints and Restraining of Residents." The policy verified that the staff were to document every hour on the restraint monitoring record and every two hours when the restraint is released and the resident is repositioned and care plan interventions have been followed.

Inspector #542 reviewed the "Restraint Monitoring Form" for resident #021 over a three week period. On four separate days the documentation indicated that the resident's restraint was applied at 1100 hours (hrs), however between 1400 to 2100 hrs there was no documentation that indicated that the resident was released from the device and repositioned during this time. [s. 110. (7) 7.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the restraint documentation for resident #021 includes every release of the device and repositioning, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs. Specifically the home failed to ensure that resident #003, #022, #045 and resident #050 were monitored for their response to the medications administered by the registered staff.

Inspector #617 reviewed the health care records for resident #003 which indicated that the Medication Administration Record (MAR) over a one month period had documentation of the administration of two analgesics on nine separate occasions with no documentation of the drug effectiveness.

Inspector #617 reviewed the health care records for resident #050 which indicated that the MAR had documentation of the administration of two medications on three separate occasions with no documentation of the drug effectiveness.

Inspector #617 reviewed the health care records for resident #045 which indicated that the MAR had documentation of the administration of a medication on a specific day without documentation of the drug effectiveness.

Inspector #542 completed a health record review for resident #022. The most current care plan indicated that the resident had pain and one of the interventions was to administer the analgesia regularly and as needed, documenting time given and effectiveness. The current Medication Administration Record (MAR) indicated that the resident received numerous pain medications. It was noted on a specific day, resident #022 received a narcotic, however there was no documentation on the MAR or progress notes to indicate whether the medication was effective or not. On a different day, the resident received another narcotic on three separate occasions, however there was no documentation to support whether the medication was effective or not. During another day, the resident received a narcotic for pain, there was no documentation to assess whether the medication was effective or at relieving resident #022's pain.

Inspector #617 interviewed S#107 who reported that the registered staff are responsible to document the effectiveness of any PRN medication administered on the back of the MAR sheet for that resident.

Inspector #617 reviewed the District of Kenora Home for the Aged nursing policy # NUR 085 last updated on March 2007 which identified that effectiveness of PRN medication are to be entered in the resident's computer record. [s. 134. (a)]

2. The licensee has failed to ensure that when resident #061 was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

On September 8, 2015, resident #061 approached Inspector #196 and reported ongoing pain and requested for a specific pain intervention.

The health care record for resident #061 was reviewed for information regarding pain management. The Medication Administration Record (MAR) was reviewed over a period of a month and a half. There was documentation of a total of 13 occurrences of an analgesic having been administered and only three times was the effectiveness of the analgesia documented on the MAR. [s. 134. (a)]

3. The licensee has failed to ensure that when resident #031, #042, #050 and #061 were taking any drug or combination of drugs, including psychotropic drugs, there was at least quarterly, a documented reassessment of each resident's drug regime.

Inspector #617 reviewed the Medication Administration Record (MAR) for resident #042 as part of this inspection and identified that resident medication reviews were not completed by the physician on a quarterly basis for resident #042.

On September 4, 2015, at 1153hrs, Inspector #617 reviewed the health care record for resident #042 which indicated that medication and pharmacist reviews were conducted for the MAR however no physician review of MAR was completed.

Inspector #617 interviewed S#109 who reported that the home's procedure for medication reviews are as follows:

- the previous pharmacist would come in on a quarterly basis and review the resident's medication then document any concerns on the summary report. The report and the MAR would be added to the physician rounds binder. When the physician did their rounds they would review the summary report and the MAR and stamp for authorization for 6 months. That would be faxed to the pharmacy and the medication changes would be sent to the home. The registered staff would then have the opportunity to perform medication checks.

Inspector #617 interviewed by phone, the current pharmacist for the home who reported that they had changed the system for the medication reviews. They would document the resident's name, room number and date on the chart and to save paperwork the changes to medication are filtered through the dispensary at pharmacy. They would fax any medication changes to the physician and make changes to the prescription via computer. They were not able to confirm if the last medication review for resident #042, was current. They stated that the Inspector would have to come over to the pharmacy to inspect the medication reviews for the residents at Princess Court.

Inspector #617 interviewed the Director of Care (DOC), who reported that they were not aware that the new pharmacist had changed the process for medication reviews and confirmed that resident #042 had an outdated medication review for over a year.

On September 8, 2015, Inspector #617 then reviewed the health care records for resident #050 and was not able to find a medication review since admission. Therefore no medication review had been completed for the last two years. Resident #050 was being administered medication with a current MAR.

Inspector #617 interviewed the DOC, who confirmed that resident #050 has not had a

medication review by the physician since admission.

On September 10, 2015, Inspector #196 conducted an interview with the Assistant Director of Care (ADOC), and it was determined that resident #031 did not have a documented quarterly medication review for over a year. In addition, resident #061 had also not had a documented quarterly medication review since the time of admission, also over a year. The ADOC reported to the Inspector that they had brought forward the concern with having a lack of current physician orders to the management team and it had not been rectified. [s. 134. (c)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that training was provided to all staff who apply physical devices or who monitor residents restrained by a physical device, including: application of these physical devices, use of these physical devices, and potential dangers of these physical devices.

The Inspectors observed numerous residents that had a restraint applied to their wheelchairs. Several observations where made over the course of a week in which the Inspectors observed the restraints to be applied incorrectly, either too loose or secured around the wheelchair as opposed to around the resident first. Inspector #542 was unable to locate any procedure in the home on the application of these restraints.

Inspector #542 interviewed three Personal Support Workers (PSWS) who indicated that they have never received training on the application of the restraints and that they just do what the other staff members do.

Inspector #542 spoke with the Assistant Director of Care (ADOC) who was responsible for the restraints in the home. The ADOC informed this Inspector that the training on restraints for the staff had not occurred for this year. The ADOC also stated that all of the staff did not receive their required training in 2013 and 2014 and was unable to provide this Inspector with any records. Inspector #542 asked if there was any training for the new hires and the ADOC stated that the other Assistant Director of Care completes all of the training for the new hires and she was unable to recall if they provided training on the application of the physical devices at the time of hire.

Inspector #542 spoke with the other ADOC who confirmed that they did not provide any training on the application of the physical devices used to restrain the residents. [s. 221. (1) 5.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

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. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the information that was gathered on every shift about the residents' infections was analyzed daily to detect the presence of infection and reviewed at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks.

Inspector #542 spoke with home's the Assistant Director of Care (ADOC) who is also the Infection Prevention and Control Lead. The ADOC confirmed that they are not analyzing the data from each shift daily to detect the presence of infection. The registered staff record when a resident is having signs and symptoms of an infection however, the lead stated that they are not analyzing this data for months later. [s. 229. (6)]

2. The licensee has failed to ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission, unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of this screening were available to the licensee.

Inspector #542 reviewed the Infection Prevention and Control LTCH Licensee Confirmation Checklist that was completed by the one of the ADOC's who is also the Infection Prevention and Control lead. It was noted on the checklist that the home has not been completing the screening for TB within 14 days of admission for the residents. Inspector #542 spoke with the home's lead, who confirmed that all of the residents are not screened for TB within the first 14 days of admission. Resident #032 and #033 have been in the home for more than 14 days and have not received the required TB screening.[s. 229. (10) 1.]

3. The licensee has failed to ensure that residents were offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Inspector #542 reviewed the Infection Prevention and Control checklist that was completed by the home's IPAC lead. It was noted that the home is not offering the tetanus and diphtheria vaccine. Inspector #542 spoke with the lead who confirmed that the home is not offering this vaccine to the residents, however they are offering the pneumococcus vaccine. [s. 229. (10) 3.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the information that is gathered on every shift about the residents' infections is analyzed daily to detect the presence of infection and reviewed at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for resident #042 that set out clear directions to staff and others who provided direct care to resident #042.

On September 1, 2015, at 1334hrs, during stage one of the Resident Quality Inspection, Inspector #597 observed a urine odor in the bathroom and soiled incontinent products were found in the bed side cabinet and closet in resident #042's room.

On September 3, 2015 at 1137hrs, and on September 4, 2015 at 1136hrs and 1516hrs, Inspector #617 observed a soiled incontinent product in the top drawer of resident #042's bed side table with an open container of chocolates in the same drawer.

Inspector #617 reviewed the health care records for resident #042 which indicated a diagnosis of dementia. The care plan for resident #042, indicated specific interventions for continence care and dementia. The staff were to check the resident's room for soiled items.

Inspector #617 interviewed S#110 who reported that they cue resident #042 to toilet after every meal and at bedtime and that staff check resident #042's room on nights and in the morning for soiled items.

Inspector #617 interviewed S#110 who reported that resident #042 had just started to leave soiled items in their room. The staff would check resident #042's rooms during the night and early am to remove the soiled items and only go into the room when the resident is not in there as it upsets them when they look through their room.

The care plan for resident #042 did not give clear directions to the staff in removing the hidden soiled items from the room to prevent odours and contamination of resident's stored food. [s. 6. (1) (c)]

2. The licensee has failed to ensure that resident #061, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

On September 8, 2015, resident #061 approached Inspector #196 and reported ongoing pain and that they had made a request for specific pain intervention to help relieve the

pain. In addition, the resident reported that they have been asking about receiving the specific pain intervention for the past month but nothing has been done.

The health care records for resident #061 were reviewed for information regarding their pain. The physician's communication book included a note for the physician and noted that resident #061's had requested to have the specific pain intervention. The progress notes during this month period included resident requesting another specific pain intervention. Noted in rounds binder, a note from another health care professional, indicating that they would discuss the pain intervention with the physician. The progress notes for five different days over a one week period that resident #061 needed an analgesic for their pain.

Resident #061 had been experiencing ongoing pain and despite bringing it forward to staff in the home, and the registered staff's documentation of ongoing pain, they were not provided with an opportunity to participate fully in their plan of care. [s. 6. (5)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to resident #033 and #048 as specified in the plan.

On September 8, 2015 at 1645hrs, Inspector #196 observed a bed alarm sounding from resident #033's room. Upon entry to the room, observed resident #033 standing at the bedside attempting to pull the sheets up to make the bed and they stated "scares me at night", related to the noise of the alarm. Within a minute of entering the room, S#101 entered and turned off the alarm at the head of the bed and asked the resident if they were ready to come for supper. Inspector #196 asked S#101 if they needed the bed alarm and S#101 stated "I don't work down this side so I am not sure". S#101 then left the room and the resident remained standing at the bedside, no walker in reach.

The current care plan was reviewed for information related to risk for falls and Activities of Daily Living (ADL) assistance/functional rehabilitation. It indicated that this resident required staff for transferring, staff assist with bed mobility and for locomotion, the resident required the use of an assisted aid while in their room. It also indicated that to minimize risk of injury from falls, use an assistive device in the room with staff assist, personal alarm on wheelchair and a bed alarm was implemented as a trial. Resident #033, who was at risk of injury from falls, was not provided with care as per the plan of care on September 8, 2015. Specifically, resident #033 was not provided with the use the assistive device while in their room nor staff assistance with transferring. [s. 6. (7)]

4. Inspector #617 reviewed two Critical Incident (CI) reports that were submitted to the Director regarding resident to resident abuse.The CI reports indicated that resident #048 was observed touching resident #049 inappropriately. And on the same day resident #048 was found to be touching resident #050 inappropriately.

Inspector #617 reviewed the health care records for resident #048 which identified a Resident Assessment Protocol (RAP) dated March 26, 2015, that indicated the resident was showing signs of inappropriate touching with staff and residents.

Inspector #617 reviewed the care plan for resident #048 which was last updated July 20, 2015, which included the following interventions to manage the resident's behaviours:

- staff to perform hourly checks

On September 8, 2015 at 1614hrs and at 1725hrs, Inspector #617 observed resident #049 sitting in the wheelchair in the TV room on the other side of the table with resident #048 and there were no staff members monitoring the residents.

Inspector #617 was not able to interview resident #048, resident #049 or resident #050 due to their cognitive impairment and difficulty expressing themselves.

Inspector #617 reviewed the health care records for resident #048 which indicated that within a one month period, it was documented that resident #048 had touched other residents inappropriately on five separate occasions.

Inspector #617 reviewed the health care record for resident #048 and was not able to find documentation on hourly checks.

Inspector #617 interviewed S#115, who reported that they had not completed or documented hourly checks for resident #048. Inspector #617 interviewed S#106 who reported that residents were on hourly checks would have been documented on a flow sheet separate from the care flow sheets and can be found on their health care record.

Inspector #617 interviewed the Director of Care (DOC) and RAI Coordinator regarding hourly checks for responsive behaviour documentation. The DOC confirmed to Inspector #617 that the hourly flow sheets were not completed for the months of March and April 2015 for resident #048. [s. 6. (7)]

5. The licensee has failed to ensure that resident #021 and #061 were reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

On September 3, 2015, Inspector #542 completed a health care record review for resident #021. The progress notes and the physician's order sheets revealed specific interventions for resident #021 pertaining to their health problem. Inspector #542 reviewed the most current care plan accessible to the direct care staff and noted that their were no specific interventions listed on the care plan with regards to their health problem. Inspector #542 spoke with the RAI coordinator who indicated that interventions specific to the resident's health problem should be on the most recent care plan.

Inspector #196 noted that resident #061 had been experiencing pain as documented in the progress notes in August and September 2015 and as reported to Inspector #196 on September 9, 2015. The current care plan was reviewed for information regarding pain and it did not contain reference to their specific pain.

Resident #061 and #021's care plan was not reviewed and revised to reflect their current care needs. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for resident #042 that sets out clear directions to staff and others who provide direct care to the resident, that the resident or the resident's SDM is given the opportunity to participate fully in the development and implementation of resident #61's plan of care and that the care set out in the plan of care is provided to resident #033 and #048 as specified in the plan, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following regulation was complied with:

All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to were kept closed and locked.

On August 31, 2015 at 1410hrs, Inspector #617 was able to access the double doors (labeled Staff Area) on the main residential area adjacent to the activity room that access the kitchen, supply room and receiving dock. Inspector #617 interviewed S#112, #113 and #114 who all reported that the double doors are not to remain locked and residents who wear wander guards approaching the doors will activate the magnetic lock.

On August 31, 2015 at 1610hrs, Inspector #617 was able to open the door to the shower room adjacent to the service elevator on the 3rd level during the initial tour of the home. Inspector #617 observed several containers of cleaning products, mechanical lifts, slings and treatment creams in a wall cupboard that was also left unlocked.

Inspector #617 interviewed S#111, who reported that they had just come on shift on to the floor. They were not aware that the shower door was left unlocked and confirmed that the door is to remain locked at all times.

On September 1, 2015, at 1725hrs Inspector #542 was able to enter the double doors (labeled Staff Area) and access the outside of the building through the open and unlocked receiving door. The home had received a delivery of supplies and the door was not locked after the supplier left. There were no staff observed in the area of the supply room.

Inspector #617 interviewed S#114 and S#112 who both confirmed that the loading dock doors are to remain locked at all times when staff are not in the area of the supply room.

Residents not wearing wander guards were not protected from exiting the building through the unlocked double doors (labeled Staff Area) on the main level and had direct access to the outside of the building when the loading dock doors were left unlocked and unattended by staff. [s. 9. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rules are complied with; 1) All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to were kept closed and locked, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, specifically with regards to resident #002 and #048.

During an interview on September 1, 2015, resident #002 reported to Inspector #577 that two staff members have been 'rough' with them, the last occurrence was about a year

ago, and some staff have been rude to them. Resident declined sharing information about specific details or names of staff members with the Inspector.

On September 3, 2015, Inspector #577 spoke with the Director of Care (DOC). The DOC reported that they have had previous conversations with resident #002 about staff being rough with them and resident did not disclose specific details or staff names. The DOC stated that resident #002 had described 'rough' as staff grabbing their legs when repositioning and felt staff were rude but nothing specific. They also reported that the complaint was not investigated, they did not have any investigative notes and it was not reported to the Director. They further reported that they talked to staff in huddles about how residents like to be talked to with respect and understanding disease processes.

On September 4, 2015, Inspector #577 reviewed the home's complaint log book. Inspector found written documentation by the DOC, dated January, 2015. The documentation indicated that when delivering supplies to resident, they stated that they were having issues with some staff.

Inspector #617 reviewed a Critical Incident (CI) report which indicated that resident #048 was observed touching resident #049 inappropriately. The CI was submitted to the Director two days after the incident had occurred.

Inspector #617 reviewed another CI report, which indicated that resident #048 touched resident #050 inappropriately. The CI was reported to the Director two days after the incident occurred.

Inspector #617 reviewed the health care records for resident #048 which identified four progress notes from four different days regarding sexually abusive behaviour towards another resident that occurred and were not reported to the Director.

Inspector #617 interviewed the Director of Care (DOC), on September 15, 2015, over the phone regarding the late reporting of the incidents to the Director. The DOC confirmed that they were late in reporting and that the registered staff usually report the critical incidents immediately to them unfortunately they are not sure why the reports were late. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that they immediately report the suspicion and the information upon which it is based to the Director: 2) Abuse of a resident by anyone or neglect of a resident by the licensee or staf that resulted in harm or risk of harm to the resident, specifically pertaining to resident #002 and #048, to be implemented voluntarily.

WN #8: 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:

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 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy on Minimizing of Restraining was complied with.

On Septmember 9, 2015, Inspector #542 spoke with the Assistant Director of Care who is the lead for the restraints in the home. This Inspector asked if they could provide the Minimizing Restraint Policy of the home. The ADOC provided Inspector #542 with the policy titled, "Restraints - Minimizing Use of Restraints and Restraining of Residents" policy # NUR 400. Inspector #542 reviewed the policy and noted that it did not indicate any types of physical restraints that are permitted to be used. The policy indicated that they are to include any/all alternatives that were tried/considered and why they were not suitable and to see the Alternative treatments to restraints. S#102 stated that the home does not utilize the "Alternative Treatments to Restraints Form." The policy also identified that staff are to receive annual training on restraints policies and procedures and the correct use of equipment as it relates to their jobs. S#102 informed this Inspector that all of the staff did not receive their required training for 2013 or 2014 and was unable to provide this Inspector with any records. [s. 29. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee's policy on Minimizing Restraints is complied with, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (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:
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. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care for resident #021 included alternatives to restraining that were considered, and tried, but had not been effective in addressing the risk.

On September 3, 2015, Inspector #542 observed resident #021 in their wheel chair. The resident had three different restraints applied. Inspector #542 spoke with S#117 who identified that the home tries different interventions instead of restraints, however they were unable to explain further.

Inspector #542 completed a health record review and was unable to locate any information with regards to any alternatives that were considered, and tried for resident #021. Inspector #542 spoke with the Lead for the restraints S#102, who confirmed that the home's policy does indicate that the staff are to ensure that alternatives have been tried and that there is a form that they used to use regarding the alternatives however they are not using this form at this present time. S#102 stated that any alternatives to restraining would be listed on the care plan or in the progress notes if there are any. [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 to ensure that any restraint plan of care for resident #021 includes alternatives to restraining that were considered, and tried, but have not been effective in addressing the risk, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #061's pain was not relieved by initial interventions, resident #061 was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

On September 9, 2015, resident #061 approached Inspector #196 and discussion ensued regarding continued pain and repeated request for a specific pain intervention.

The health care records for resident #061 were reviewed for information regarding their pain. The most recent documented pain assessment was completed two months ago and it indicated the resident experienced ongoing pain.

The progress notes identified continued pain since having requested the specific pain intervention from the physician in August, 2015. An additional six progress notes, refer to pain that resident #061 was experiencing.

There were no further pain assessments documented after after the last assessment to reflect the current pain situation of resident #061, despite having several progress notes identifying ongoing pain. [s. 52. (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 to ensure that when resident #061's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that, if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

On September 9, 2015 an interview was conducted with resident #065, and it was reported that the minutes of the Residents' Council meetings are provided to the department heads in the home for them to address any concerns that had been brought forward in the meetings. Resident #065 also reported that they have not received any written responses from the licensee with regard to any concerns identified in the meeting minutes.

A review of the minutes from the past year's Residents' Council meetings was completed and identified some recurring concerns in the areas of laundry, environmental and nursing.

On September 10, 2015, an interview was conducted with the home's administrator and they reported that they have never received any written concerns/complaints from the council, only the meeting minutes, nor have they responded to the council in writing with regard to any complaints or concerns. [s. 57. (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 to ensure that when the Residents' Council advises the licensee of their concerns or recommendations, the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey is sought and to act on its results.

An interview was conducted with resident #065 on September 9, 2015, and it was reported that the Residents' Council members have not had any input into the development of the satisfaction survey for the home. The administrator confirmed to Inspector #196 that the Residents' Council had not been involved in the development of the satisfaction survey and their had been no formal plan made to act on the results. [s. 85. (3)]

2. The licensee has failed to ensure that they seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

Inspector #542 reviewed the Quality Improvement and Required Programs checklist that was submitted to the Inspector by the home's Administrator. It was noted that the home answered "no" to seeking the advice of the Family Council in developing and carrying out the survey and in acting on its results. On September 10, 2015, Inspector #542 spoke with the President of the Family Council who confirmed that the licensee does not seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results, however they do see the results of the survey. [s. 85. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that they seek the advice of the Residents' Council and Family Council, if any, in developing and carrying out the survey, and in acting on its results, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that, electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum.

Inspection findings from stage 1 of the Resident Quality Inspection identified that exposed wires were observed on the bed controller cord in a resident's room, by Inspector #597. Inspector #617 observed bed controller cords attached to resident beds, frayed with exposed wires in three other resident rooms.

Inspector #617 also observed the wire attached to another resident's bed/chair alarm had exposed wires on the cord.

On September 10, 2015, Inspector #617 interviewed S#104 and S#116, who both confirmed that the above resident rooms had bed controller cords that were frayed with exposed wires. Both reported that they had completed and submitted a maintenance requisition several times to request the maintenance department to repair the cords but the repairs have not been completed.

Inspector #617 reviewed the completed maintenance forms over a nine month period, and found that a requisition was completed in July, 2015 requesting the exposed wires on the bed controller cord in one of the rooms to be repaired. It also identified that the cord was repaired with tape. No completed requisitions to request cord repair for the additional rooms were found.

Inspector #617 interviewed S#112 from the Maintenance Department, who reported that they were responsible to complete monthly scheduled maintenance checks. They stated that it is the responsibility of the staff to notify the maintenance department of electrical cords needing repairs as this is not part of the monthly checks. Inspector #617 interviewed the Administrator who confirmed that the staff are responsible to submit the maintenance requisition when electrical equipment needs repair.

The home has electrical cords with exposed wires on resident beds that need repair despite a system that is in place to identify and report the needs. The residents are at a safety risk when using the electrical cords with frayed wires. [s. 90. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented to ensure that, electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy on Minimizing of Restraining addressed types of physical devices permitted to be used.

On Septmember 9, 2015, Inspector #542 spoke with the Assistant Director of Care (ADOC) who is also the lead for the restraints in the home. This Inspector asked if they could provide the Minimizing Restraint Policy of the home. They explained that some of the policies and forms located on the "shared" drive on the computer are currently not being used. They provided the Inspector with the policy titled, "Restraints - Minimizing Use of Restraints and Restraining of Residents" policy # NUR 400. Inspector #542 reviewed the policy and noted that it did not indicate any types of physical restraints that are permitted to be used. [s. 109. (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the policy on Minimizing Restraints addresses the types of physical devices permitted to be used, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that a monthly analysis of the restraining of residents by use of a physical device is undertaken.

Inspector #542 spoke with the Assistant Director of Care, who is the also the lead for the restraints in the home. They confirmed that the licensee does not conduct a monthly analysis on the restraining of residents. [s. 113. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a monthly analysis of the restraining of residents by use of a physical device is undertaken, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart, that complies with manufacturer's instructions for the storage of the drugs.

On September 9, 2015 during the review of the first floor medication cart, several medications were noted to be expired. They included:
Gravol suppositories expired Dec. 2014, Senekot expired May 2014, Imodium gel caps expired August 2015, Guafenesin expired January 2015. [s. 129. (1) (a)]

2. The licensee has failed to ensure that, drugs were stored in an area or a medication cart, controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On September 9, 2015, the first floor medication room was observed in the presence of S #117. The narcotic cupboard that had a double lock, within the medication room, contained narcotics and prn (as needed) Ativan for residents. The blister packs hanging on the wall in the medication room, contained regular dosing of controlled substances, specifically Ativan. This regular dosing of the controlled substance Ativan was not double locked. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart, that complies with manufacturer's instructions for the storage of the drugs, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents were fully respected and promoted: Every resident has the right to, 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.

On September 10, 2015, S#118 reported to the Inspector that medication labels that contain the residents name and the name of medications, are not shredded and instead are disposed in the regular garbage. [s. 3. (1) 11. iv.]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was, an organized program of personal support services for the home to meet the assessed needs of resident #008.

On September 10, 2015 at 1608hrs, Inspector #196 observed the bed alarm in resident #008's room to be ringing. Inspector #196 entered the resident room and the resident was seated in their wheelchair, bed alarm ringing and light flashing outside of the resident room. Inspector #196 then walked through both corridors of the hallways to locate a staff member, none to be found. The alarm was ringing audibly at the nursing desk on this unit. The Inspector returned to the resident's room and alarm remained ringing at the bedside. Resident #008 stated that they wanted to go to the washroom and put themselves in the wheelchair.

At 1618hrs, as Inspector #196 was walking from the resident #008's room to the nursing desk, S#118 stated that they were coming to check the bed alarm, the Inspector informed them that it had been ringing for at minimum 10 minutes and no staff were to be found on the unit, and they reported that they were short one PSW and that they had been off the unit on their break. When Inspector approached the nursing desk, as the alarm was still ringing, a PSW came out of the resident washroom across from desk and stated they were going to check alarm and had been in washroom with a resident and S#109. S#109 stated repeatedly "sorry, sorry", when asked if they had heard the bed alarm.

S#118, entered the residents room and stated "we try to respond quickly, sometimes resident #008 is okay and sometimes their not".

The current care plan for resident #008 was reviewed and under the focus of "risk of injury from falls", it included the intervention of "bed alarm". The outcome notes, noted "Resident has had two falls this month, wheel chair is to be locked when left at bedside for resident and they are encouraged to use their call bell for assist to get up. Bed alarm placed on bed by DOC earlier this week following second fall. Care plan updated to reflect this".

On September 10, 2015, on the evening shift, resident #008 was not provided with response to a bed alarm in place to reduce the incidence of falls, as it was reported the unit was short one PSW. [s. 8. (1) (b)]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 10. Recreational and social activities

Specifically failed to comply with the following:

s. 10. (2) Without restricting the generality of subsection (1), the program shall include services for residents with cognitive impairments, and residents who are unable to leave their rooms. 2007, c. 8, s. 10 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the recreational and social activities program included services for residents with cognitive impairments and residents who were unable to leave their room.

Over the course of the inspection, Inspector #542 observed resident #023 sitting in their wheel chair, wandering the halls. This Inspector did not observe any recreation and social activities being offered to the resident. A health care record review was completed for resident #023. The most recent care plan accessible to the direct care team indicated that the resident enjoyed the following activities: exercise and sports, walk/wheel outdoors, watching tv, gardening or working with plants, and outdoors.

On September 9, 2015, Inspector #542 spoke with S#119 from the Recreation and Therapy Department, who stated that they try and provide the resident with 1-1, spend time talking to them and painting. Inspector #542 asked where the activity participation is documented, S#119 stated that there is an excel spreadsheet where they document the resident's attendance at activities, however they were unable to access the spreadsheet.

Inspector spoke with S#120, who was able to access the excel spreadsheet and verified that during the month of July and August it was documented that the resident was offered and attended three fun and fitness activities and no other documentation of any other activities. Inspector #542 spoke with S#121 and S#122 who stated that they do not believe that resident #023 attends any activities.

Inspector spoke with the Lead for the Recreation and Social Activities program who indicated that the home does not typically provide 1-1 activation to the residents as they do not have enough staff and stated that resident #023 is challenging because they won't stay at a group activity. [s. 10. (2)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, cleaned as required.

On September 01, 2015, at 1209hrs, Inspector #577 observed that the table top on resident #021's wheelchair was unclean with stained food at 1105hrs. Inspector #577 observed the restraint, wheelchair, table top and walker for resident #047 was stained and soiled with food.

Inspector #617 interviewed S#110 who reported that resident wheelchairs and walkers were scheduled to be cleaned by the PSWs on night shift. S#110 stated they don't work nights but stated that the wheelchairs are cleaned in shower room and the seat cushion covers are hung to dry.

Inspector #617 reviewed the equipment cleaning schedule for resident #047 and #021 which indicated that the equipment was scheduled to be cleaned once a week. Inspector #617 observed that the restraint for resident #047 was stained on three separate occasions.

Despite a cleaning schedule for resident assistive devices, the home failed to ensure that both resident #021 and resident #047 devices were cleaned as required. [s. 37. (1) (b)]

WN #21: 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:

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; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent received an assessment that included 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 required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Resident #004 was indicated as requiring further inspection during Stage 1 due to having a specific urinary intervention.

On September 4, 2015, Inspector #577 reviewed resident #004's progress notes from December 2014 - July 2015 and found that the resident's urinary status had changed on four separate occasions.

Inspector #577 reviewed the home's 'Continence Care and Bowel Management program', policy # NUR 210, revision date 06/14, which indicated that a bladder and bowel assessment is done on admission and whenever there is a change in condition.

During a record review, Inspector found two bladder/bowel assessment's completed. One was completed in 2013 and in April 2015. The Director of Care confirmed that there were no other completed continence assessments.

On September 9, 2015, Inspector #577 spoke with the DOC, who confirmed that the paper form "Bladder and bowel assessment" is considered the home's clinical tool, and should be completed annually and when there is a change in condition. [s. 51. (2) (a)]

WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that they respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

On September 10, 2015, Inspector #542 spoke with the President of the Family Council. They stated that the Family Council was established last year. They also indicated that the home does not provide a respond to their concerns or recommendations within 10 days of receiving them nor do they respond in writing. Inspector #542 also spoke to the appointed assistant for the Family Council who also confirmed that the home is not responding to concerns or recommendations in writing. [s. 60. (2)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 66. Designated lead

Specifically failed to comply with the following:

s. 66. (2) The designated lead must have,
(a) a post-secondary diploma or degree in recreation and leisure studies, therapeutic recreation, kinesiology or other related field from a community college or university; and O. Reg. 79/10, s. 66 (2).
(b) at least one year of experience in a health care setting. O. Reg. 79/10, s. 66 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the designated lead for the recreational and social activities program have: a post-secondary diploma or degree in recreation and leisure studies, therapeutic recreation, kinesiology, or other related field from a community college or university; and at least one year of experience in a health care setting.

Inspector #542 spoke to the designated lead for the recreational and social activities program who confirmed that they did not hold a post secondary diploma or degree of any designation. Inspector #542 and #196 spoke to the Administrator who confirmed that the staff member does not have a post-secondary diploma or degree in the required fields. [s. 66. (2)]

WN #24: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)

(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information was posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

On August 31, 2015, Inspector #617 completed an initial tour of the home and observed the Ministry of Health and Long Term Care Action Line for reporting matters posted in the public elevator and on the wall across from that elevator on the main floor with a tall artificial tree in front of it obstructing the view. The home has three levels of care areas and not all residents, family members and staff access or use the public elevator to be able to view the posting in the elevator.

Inspector #617 interviewed the Administrator who reported that the action line posting is located across from and inside the public elevator. Both the administrator and Inspector walked up to the posting which had the tree in front of the posting obscuring its view. The Administrator confirmed that the tree obstructed the view of the posting.

Those residents, family members and staff that do not use the public elevator that live, visit or work on the first level may not use the elevator and their view of the action line posting was obscured. [s. 79. (1)]

2. The licensee has failed to ensure that copies of the inspection reports from the past two years for the long-term care home were posted in the home for the public to view.

On August 31, 2015, Inspector #617 conducted an initial tour of the home and observed that the public copies of inspection reports were bound together with a paper clip and posted on the bulletin board on the wall beside the service elevator and across from the administration office entrance.

Inspector #617 reviewed the reports posted and compared that with the reports issued to the home over the past 2 years and found that the following reports were missing from the posting:
2014_333577_0019 – Complaint
2014_211106_0019 – Follow up
2014_211106_0020 – Critical Incident System [s. 79. (3) (k)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

During the course of inspection, several different areas of non-compliance related to the licensee's medication management system were identified.

On September 11, 2015, Inspector #196 interviewed the Assistant Director of Care and the Administrator regarding quarterly medication meetings with the pharmacist, administrator, DOC. Both reported that there were no formal meetings held regarding the medication processes. [s. 115. (1)]

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

During the course of inspection, several different areas of non-compliance related to the licensee's medication management system were identified.

On September 11, 2015, Inspector #196 interviewed Assistant Director of Care #102 and the Administrator regarding annual medication meetings with the pharmacist, administrator, DOC and Registered Dietitian. Both reported that there were no formal meetings held regarding the medication processes. [s. 116. (1)]

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is acquired, received or stored by or in the home or kept by a resident unless the drug, has been prescribed for a resident or obtained for the purposes of the emergency drug supply.

During a review of the narcotic storage cupboard on September 9, 2015, Inspector #196 found a medication in a bin labelled with resident #061's name and the date. Inspector spoke with S#117 about the medication in the narcotic cupboard. The staff member was unaware of the resident's request to have this medication, they had not heard about it and reported that the physician may have sent an order to the pharmacy and they might not have an order. An interview was conducted with the DOC and with S#123 regarding the resident's request for this pain medication. The DOC reported that there was no order for the medication and they had only received the order for it recently. Inspector #196 reported to the DOC and S#123 that there was a medication in the narcotic storage cupboard, for resident #061.

Medication was received by the home and placed into the narcotic storage cupboard for resident #061, yet there was no order for this medication and registered staff working, were unaware it was there. [s. 122. (1)]

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug had been prescribed for the resident.

On September 10, 2015, at 1225 hrs, the medication administration by S #118 for resident #031 was observed. The resident received four different medications.

The health care record for resident #031 was reviewed and the most recent quarterly medication review was from two years ago was signed by the physician and stamped "weekly refills for 6 months". The ADOC on Sept 10, 2015 confirmed to the Inspector that there were no current orders to for any medications as the stamp identified that a limit of 6 months of medications were ordered.

The health care record for resident #061 was reviewed by Inspector #196 and the ADOC on September 10, 2015, for the current medication orders and quarterly medication reviews since the residents admission to the home last year. There were three faxed pages on the hard copy of the resident's chart that included the physician's orders from the time of admission to the home and there was no documentation of a quarterly medication review since that time.

The licensee's policy titled "Medication Program - Structure" #NUR 085 with revision date of November 2006 identified that "physician's orders expire every 3 months. The quarterly medication review produces your physician orders"

Medications were administered to resident #031 and #061 despite not having current physician's orders. [s. 131. (1)]

Issued on this 22nd day of December, 2015

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

Original report signed by the inspector.

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) :	JENNIFER LAURICELLA (542), DEBBIE WARPULA (577), LAUREN TENHUNEN (196), SHEILA CLARK (617)
Inspection No. / No de l'inspection :	2015_281542_0017
Log No. / Registre no:	018934-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 7, 2015
Licensee / Titulaire de permis :	BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA 1220 Valley Drive, KENORA, ON, P9N-2W7
LTC Home / Foyer de SLD :	PRINCESS COURT PRINCESS STREET, BOX 725, DRYDEN, ON, P8N-2Z4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PATRICK BERREY

To BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for ensuring that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act;

1) To ensure that all physical devices that are applied to residents are done so in accordance with any manufacturer's instructions and how the home proposes to ensure that this is sustained.

The plan shall include time frames for development and implementation and identify the staff member (s) responsible for implementation.

The plan shall be submitted in writing to Jennifer Lauricella, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5 or Fax at 1 705 564-3133. This plan must be submitted by December 14, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that the restraints for resident #004, #005, #025, #026, #027, #028, #029 and #030 and #047 were applied in accordance with the manufacturer's instructions.

On August 31, 2015, Inspector #542 observed resident #026 in their wheel chair with a restraint on. The restraint ends were wrapped around the outside of the wheel chair sides and then secured to the back of the wheel chair, instead of around the resident and then secured to the back. The restraint was noted to be very loose and not secured properly. Inspector #542 immediately spoke with S#100 who agreed that the restraint was not applied correctly and that it was ill fitting. S#100 re-applied the restraint correctly for this resident at that time.

On September 2, 2015, Inspector #577 observed resident #004 to be sitting in their wheelchair with a applied to outer sides of wheelchair. The restraint was observed to be very loose in front of the resident.

On September 3, 2015, Inspector #577 observed residents #047, #025 and #029 to be sitting in their wheelchairs with restraints on and applied to the outer sides of the wheelchair. A short time later, resident #047 remained up in their wheelchair and the Director of Care (DOC) was on the unit. Inspector #577 spoke with the DOC and asked about the application the restraints in a wheelchair. The DOC confirmed that the restraint used by resident #047 was incorrectly applied to the outside of the wheelchair. Inspector observed the DOC secure the restraint around the resident and to the inside of the wheelchair, securing it at the back of the wheelchair. Later that same day, Inspector again observed residents #004, #030, #029, #028 and #025 to be up in their wheelchairs with a restraint on and applied to the outsides of their wheelchairs.

On September 3, 2015, Inspector #542 observed resident #025 in their wheel chair with a restraint in place. The restraint was wrapped around the wheel chair sides instead of around the resident, and this restraint was also too loose for the resident. Inspector #542 spoke to S#101 who verified that the restraint was too loose.

On September 4, 2015, Inspector #577 toured a specific home area with the DOC and observed residents #004, #025, #028 and #047 sitting in their wheelchairs with their restraints attached to the outside of their wheelchairs. The DOC further confirmed that the restraints were applied incorrectly.

Inspector #577 received the manufacturer's instructions for the application of restraints from the DOC. The instructions indicated "bring the ends of the connecting straps on the narrow end, down between the seat and the wheelchair sides. Secure the straps behind the backrest. Bring the ends of the connecting

straps on the wide end, down between the seat and wheelchair sides at a 45 degree angle. Secure the straps behind the backrest as low as possible. Check that the straps are secure and will not change position, loosen, or tighten if the resident pulls on them, or if the chair is tilted or adjusted". The picture illustrated that the straps are secured between the seat and wheelchair sides.

On September 9, 2015, Inspector #577 spoke with the DOC who indicated that the Assistant Director of Care (ADOC) trains the staff on restraints and that they did not teach them to apply the restraints on the outside of the wheel chair.

On September 10, 2015, Inspector #196 observed resident's #026, #005, #027 and #028 all with a restraint incorrectly applied. Inspector #542 and #196 proceeded to inform the Administrator and the ADOC. The ADOC agreed that the restraints were applied incorrectly.

Three previous written notifications (WN) of non compliance have been issued. Including one voluntary plan of correction (VPC) issued in November 2012 during inspection # 2012_211106_0003 and in May 2013 during inspection # 2013_246196_0009. One previous compliance order (CO) was issued in September 2014 during inspection #2014_211106_0009; pursuant to O.Reg 79/10, r. 110.

The decision to issue this compliance order was based on the severity which indicates a potential for actual harm, the scope which affected numerous residents and the compliance history which despite previous non-compliance (NC) issued including one compliance order and two voluntary plan of corrections, NC has continued for approximately three years with this area of the legislation.

(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 21, 2015

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. 134. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Order / Ordre :

The licensee shall ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is a monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs and there is, at least quarterly, a documented reassessment of each resident's drug regime.

Grounds / Motifs :

1. The licensee has failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs. Specifically the home failed to ensure that resident #003, #022, #045 and resident #050 were monitored for their response to the medications administered by the registered staff.

Inspector #617 reviewed the health care records for resident #003 which indicated that the Medication Administration Record (MAR) over a one month period had documentation of the administration of two analgesics on nine separate occasions with no documentation of the drug effectiveness.

Inspector #617 reviewed the health care records for resident #050 which indicated that the MAR had documentation of the administration of two medications on three separate occasions with no documentation of the drug effectiveness.

Inspector #617 reviewed the health care records for resident #045 which indicated that the MAR had documentation of the administration of a medication on a specific day, without documentation of the drug effectiveness.

Inspector #542 completed a health record review for resident #022. The most current care plan indicated that the resident had pain and one of the interventions was to administer the analgesia regularly and as needed, documenting time given and effectiveness. The current Medication Administration Record (MAR) indicated that the resident received numerous pain medications. It was noted on a specific day, resident #022 received a narcotic, however there was no documentation on the MAR or progress notes to indicate whether the medication was effective or not. On a different day, the resident received another narcotic on three separate occasions, however there was no documentation to support whether the medication was effective or not. During another day, the resident received a narcotic for pain, there was no documentation to assess whether the medication was effective or at relieving resident #022's pain.

Inspector #617 interviewed S#107 who reported that the registered staff are responsible to document the effectiveness of any PRN medication administered on the back of the MAR sheet for that resident.

Inspector #617 reviewed the District of Kenora Home for the Aged nursing policy # NUR 085 last updated on March 2007 which identified that effectiveness of PRN medication are to be entered in the resident's computer record. (617)

2. The licensee has failed to ensure that when resident #031, #042, #050 and #061 were taking any drug or combination of drugs, including psychotropic drugs, there was at least quarterly, a documented reassessment of each resident's drug regime.

Inspector #617 reviewed the Medication Administration Record (MAR) for resident #042 as part of this inspection and identified that resident medication reviews were not completed by the physician on a quarterly basis for resident

#042.

On September 4, 2015, at 1153hrs, Inspector #617 reviewed the health care record for resident #042 which indicated that medication and pharmacist reviews were conducted for the MAR however no physician review of MAR was completed.

Inspector #617 interviewed S#109 who reported that the home's procedure for medication reviews are as follows:

- the previous pharmacist would come in on a quarterly basis and review the resident's medication then document any concerns on the summary report. The report and the MAR would be added to the physician rounds binder. When the physician did their rounds they would review the summary report and the MAR and stamp for authorization for 6 months. That would be faxed to the pharmacy and the medication changes would be sent to the home. The registered staff would then have the opportunity to perform medication checks.

Inspector #617 interviewed by phone, the current pharmacist for the home who reported that they had changed the system for the medication reviews. They would document the resident's name, room number and date on the chart and to save paperwork the changes to medication are filtered through the dispensary at pharmacy. They would fax any medication changes to the physician and make changes to the prescription via computer. They were not able to confirm if the last medication review for resident #042, was current. They stated that the Inspector would have to come over to the pharmacy to inspect the medication reviews for the residents at Princess Court.

Inspector #617 interviewed the Director of Care (DOC), who reported that they were not aware that the new pharmacist had changed the process for medication reviews and confirmed that resident #042 had an outdated medication review for over a year.

On September 8, 2015, Inspector #617 then reviewed the health care records for resident #050 and was not able to find a medication review since admission. Therefore no medication review had been completed for the last two years. Resident #050 was being administered medication with a current MAR.

Inspector #617 interviewed the DOC, who confirmed that resident #050 has not

had a medication review by the physician since admission.

On September 10, 2015, Inspector #196 conducted an interview with the Assistant Director of Care (ADOC), and it was determined that resident #031 did not have a documented quarterly medication review for over a year. In addition, resident #061 had also not had a documented quarterly medication review since the time of admission, also over a year. The ADOC reported to the Inspector that they had brought forward the concern with having a lack of current physician orders to the management team and it had not been rectified.

Non-compliance has previously been identified under inspection 2012_211106_0003, which included a voluntary plan of correction (VPC) in November 2012, pursuant to O.Reg 79/10, r. 134 (a) Every licensee of a long-term shall ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

The decision to issue this compliance order was based on the severity which indicates a potential for actual harm, the scope which was a pattern as multiple residents were affected and the compliance history.

(617)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for ensuring that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act;

1) All direct care staff at the time of hire and annually thereafter, are trained on the proper application and the potential dangers of these physical devices used in the home to restrain a resident.

2) A process to ensure that the application of the physical devices that are applied to restrain a resident are monitored for correct application.

The plan shall include time frames for the development and the implementation and also identify the staff member (s) responsible for implementation.

The plan shall be submitted in writing to Jennifer Lauricella, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5 or Fax at 705 564 3133. This plan must be submitted by December 14, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that training was provided to all staff who apply physical devices or who monitor residents restrained by a physical device, including: application of these physical devices, use of these physical devices, and potential dangers of these physical devices.

The Inspectors observed numerous residents that had a restraint applied to their wheelchairs. Several observations where made over the course of a week in which the Inspectors observed the restraints to be applied incorrectly, either too loose or secured around the wheelchair as opposed to around the resident first. Inspector #542 was unable to locate any procedure in the home on the application of these restraints.

Inspector #542 interviewed three Personal Support Workers (PSWS) who indicated that they have never received training on the application of the restraints and that they just do what the other staff members do.

Inspector #542 spoke with the Assistant Director of Care (ADOC) who was responsible for the restraints in the home. The ADOC informed this Inspector that the training on restraints for the staff had not occurred for this year. The ADOC also stated that all of the staff did not receive their required training in 2013 and 2014 and was unable to provide this Inspector with any records. Inspector #542 asked if there was any training for the new hires and the ADOC stated that the other Assistant Director of Care completes all of the training for the new hires and she was unable to recall if they provided training on the application of the physical devices at the time of hire.

Inspector #542 spoke with the other ADOC who confirmed that they did not provide any training on the application of the physical devices used to restrain the residents.

The decision to issue this compliance order was based on the severity which indicates a potential for actual harm to the residents, the scope which presented as a pattern as numerous residents were affected by the improper application of their physical device (s).
(542)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 21, 2015

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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).

Order / Ordre :

The licensee shall ensure that each resident admitted to the home are;

1) 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) offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission, unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of this screening were available to the licensee.

Inspector #542 reviewed the Infection Prevention and Control LTCH Licensee Confirmation Checklist that was completed by the one of the ADOC's who is also the Infection Prevention and Control lead. It was noted on the checklist that the home has not been completing the screening for TB within 14 days of admission for the residents. Inspector #542 spoke with the home's lead, who confirmed that all of the residents are not screened for TB within the first 14 days of admission. Resident #032 and #033 have been in the home for more than 14 days and have not received the required TB screening. (542)

2. The licensee has failed to ensure that residents were offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Inspector #542 reviewed the Infection Prevention and Control checklist that was completed by the home's IPAC lead. It was noted that the home is not offering the tetanus and diphtheria vaccine. Inspector #542 spoke with the lead who confirmed that the home is not offering this vaccine to the residents, however they are offering the pneumococcus vaccine.

The decision to issue this compliance order was based on the severity which indicates a potential for actual harm, the scope which indicated a pattern as multiple residents were affected and a compliance history of previously issued non-compliance in this area of the legislation.

(542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

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

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
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 7th day of December, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Lauricella

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