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

Ministère 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) :	MARGOT BURNS-PROUTY (106)
Inspection No. / No de l'inspection :	2012_211106_0003
Log No. / Registre no:	S-001280-12
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 28, 2013
Licensee / Titulaire de permis :	KENORA DISTRICT HOME FOR THE AGED BOARD OF MANAGEMENT 35 Van Horne Avenue, Box 725, DRYDEN, ON, P8N-2Z4
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

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

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 53 (3) (a). The compliance plan shall include how the licensee will ensure that the matters referred to in subsection (1) in regards to a responsive behaviour program, including written approaches to care, written strategies, resident monitoring and protocols are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

This plan must be submitted in writing to Inspector Margot Burns-Prouty at 159 Cedar Street, Suite 603, Sudbury ON P3E 6A5 or by fax at 1-705-564-3133 on or before March 14, 2013. Full compliance with this order shall be by April 30, 2013.

Grounds / Motifs :

1. During a November 23, 2012 interview Staff member #S-100 reported that the home did not currently have a responsive behaviour program implemented, although had developed a responsive behaviour program that was not currently implemented. The licensee failed to ensure that , (a) the matters referred to in subsection (1) in regards to a responsive behaviour program, are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. (106)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with Regulation, s. 110 (7) 6. The compliance plan shall include how the licensee will 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: 6. All assessment, reassessment and monitoring, including the resident's response.

This plan must be submitted in writing to Inspector Margot Burns-Prouty at 159 Cedar Street, Suite 603, Sudbury ON P3E 6A5 or by fax at 1-705-564-3133 on or before March 14, 2013. Full compliance with this order shall be by April 30, 2013.

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

Grounds / Motifs :

1. The "Restraint Monitoring Forms", for 22 days, were reviewed for resident #003. During that period of time it was recorded that the resident had a restraint applied on 20 of those days. A member of the registered staff signed the form only on 7 different shifts of 66 shifts, to indicate that the resident's condition was reassessed and the effectiveness of the restraining evaluated at least every 8 hours, and at any other time when necessary based on the resident's condition or circumstances. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 6. All assessment, reassessment and monitoring, including the resident's response. (106)

2. The "Restraint Monitoring Forms", for 21 days, were reviewed for resident #002. During that period of time it was recorded that the resident had a restraint applied on 21 of those days. A member of the registered staff signed the form only on 9 of 63 shifts, to indicate that the resident's condition was reassessed and the effectiveness of the restraining evaluated at least every 8 hours, and at any other time when necessary based on the resident's condition or circumstances. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 6. All assessment, reassessment and monitoring, including the resident's response. (106)

3. The "Restraint Monitoring Forms" for resident #001 were reviewed for 28 days, the resident is recorded as having a restraint applied on 27 of those days. A member of the registered staff signed the forms only on 10 of 84 shifts to indicate that the resident's condition was assessed and the effectiveness of the restraining evaluated at least every 8 hours, and at any other time when necessary based on the resident's condition or circumstances. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 6. All assessment, reassessment and monitoring, including the resident's response. (106)

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 : Apr 30, 2013

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with s. 6 (4)(a). The compliance plan shall include how the licensee will ensure that staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, in regards to the resident's food and nutrition requirements.

This plan must be submitted in writing to Inspector Margot Burns-Prouty at 159 Cedar Street, Suite 603, Sudbury ON P3E 6A5 or by fax at 1-705-564-3133 on or before March 14, 2013. Full compliance with this order shall be by April 30, 2013.

Grounds / Motifs :

1. The "Food & Nourishment Daily Records" for September, October and November 2012 were reviewed for resident # 001. It was found that in September 2012 resident # 001 was assessed by PSWs as refusing or consuming less than 50% of meal or snacks a total of 29 times out of a total of 100 meals or snacks (or 29% of the time). It was found that in October 2012, resident #001 is assessed by PSWs as refusing or consuming less than 50% of meals or snacks a total of 76 times out of a total of 155 meals or snacks (or 49% of the time). It was found that in November 2012, resident # 001 is assessed by PSWs as refusing or consuming less than 50% of meals or snacks a total of 37 times out of a total of 38 meals or snacks (or 97% or the time).

There was no documentation found to support that the PSWs who were aware that resident #001 was regularly refusing or consuming less than 50% of meals or snacks, reported that information to registered staff. The Progress Notes and 2 post falls assessments for resident #001 were reviewed. Both post falls assessments record "no" in answer to "Recent Poor Food/fluid intake?". A progress note regarding a care conference that was held for resident #001 indicates that "75 - 100% of meals taken." Staff member # S-101 reported that they did not receive a dietary referral regarding resident # 001 until November 6, 2012.

The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, in regards to the resident's food and nutrition requirements.
(106)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2013

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 28th day of February, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : MARGOT BURNS-PROUTY

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

Ontario

Ministry of Health and Long-Term Care

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

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 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 28, 2013	2012_211106_0003	S-001280-12	Complaint

Licensee/Titulaire de permis

KENORA DISTRICT HOME FOR THE AGED BOARD OF MANAGEMENT
35 Van Horne Avenue, Box 725, DRYDEN, ON, P8N-2Z4

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

MARGOT BURNS-PROUTY (106)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 20, 21, 22, 23, 2012

Log # S-001280-12

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistance Director of Care (ADOC), RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietitian (RD), Personal Support Workers (PSW), Family Members and Residents.

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:
Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. During a November 23, 2012 interview Staff member #S-100 reported that the home did not currently have a responsive behaviour program implemented, although had developed a responsive behaviour program that was not currently implemented. The licensee failed to ensure that , (a) the matters referred to in subsection (1) in regards to a responsive behaviour program, are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [s. 53. (3) (a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
4. Consent. O. Reg. 79/10, s. 110 (7).

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:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

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).

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:
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The "Protective Devices Consent Form" for resident #001 was reviewed, it was noted that the POA and RN signed the form on the day resident #001 was admitted to the home, it was also noted that "None needed at this time (admission date)" was written at the bottom of the form. A Physician order dated 26 days after resident #001 was admitted to the home, for "Pelvic restraint PRN" was found for resident #001. No documentation was found that the POA consented to the use of the pelvic restraint once the resident required as restraint. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 4. Consent. [s. 110. (7) 4.]

2. The "Restraint Monitoring Forms" for resident #001 were reviewed for 28 days, the resident is recorded as having a restraint applied on 27 of those days. A member of the registered staff signed the forms only on 10 of 84 shifts to indicate that the resident's condition was assessed and the effectiveness of the restraining evaluated at least every 8 hours, and at any other time when necessary based on the resident's condition or circumstances. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 6. All assessment, reassessment and monitoring, including the resident's response. [s. 110. (7) 6.]

3. The "Restraint Monitoring Forms", for 21 days, were reviewed for resident #002. During that period of time it was recorded that the resident had a restraint applied on 21 of those days. A member of the registered staff signed the form only on 9 of 63 shifts, to indicate that the resident's condition was reassessed and the effectiveness of the restraining evaluated at least every 8 hours, and at any other time when necessary based on the resident's condition or circumstances. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 6. All assessment, reassessment and monitoring, including the resident's response. [s. 110. (7) 6.]

4. The "Restraint Monitoring Forms",for 22 days, were reviewed for resident #003. During that period of time it was recorded that the resident had a restraint applied on 20 of those days. A member of the registered staff signed the form only on 7 of 66 shifts, to indicate that the resident's condition was reassessed and the effectiveness of

the restraining evaluated at least every 8 hours, and at any other time when necessary based on the resident's condition or circumstances. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 6. All assessment, reassessment and monitoring, including the resident's response. [s. 110. (7) 6.]

5. The "Restraint Monitoring Forms" for resident #001 were reviewed for 28 days, the resident is recorded as having a restraint applied on 27 of those days. On 10 different days, it was not documented that resident #001 was released from the physical device and repositioned at least once every two hours. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 7. Every release of the device and all repositioning. [s. 110. (7) 7.]

6. The "Restraint Monitoring Forms" for resident #001 were reviewed for 28 days, the resident is recorded as having a restraint applied on 27 of those days. On 13 different days, it is not indicated on the "Restraint Monitoring Form" when the restraint was removed. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. [s. 110. (7) 8.]

Additional Required Actions:

CO # - 002 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 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: Consent, every release of the device and all repositioning, and removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care, to be implemented voluntarily.

WN #3: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The "Food & Nourishment Daily Records" for September, October and November 2012 were reviewed for resident # 001. It was found that in September 2012 resident # 001 was assessed by PSWs as refusing or consuming less than 50% of meal or snacks a total of 29 times out of a total of 100 meals or snacks (or 29% of the time). It was found that in October 2012, resident #001 is assessed by PSWs as refusing or consuming less than 50% of meals or snacks a total of 76 times out of a total of 155 meals or snacks (or 49% of the time). It was found that in November 2012, resident # 001 is assessed by PSWs as refusing or consuming less than 50% of meals or snacks a total of 37 times out of a total of 38 meals or snacks (or 97% or the time).

There was no documentation found to support that the PSWs who were aware that resident #001 was regularly refusing or consuming less than 50% of meals or snacks, reported that information to registered staff. The Progress Notes and 2 post falls assessments for resident #001 were reviewed. Both post falls assessments record "no" in answer to "Recent Poor Food/fluid intake?" . A progress note regarding a care conference that was held for resident #001 indicates that "75 - 100% of meals taken." Staff member # S-101 reported that they did not receive a dietary referral regarding resident # 001 until November 6, 2012.

The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, in regards to the resident's food and nutrition requirements. [s. 6. (4) (a)]

2. The plan of care for resident #001 was reviewed, in the section titled "Behaviour Problem" there is the following intervention, "Aggression: Discuss past history if angry outbursts with family i.e. situations that trigger anger, successful past coping mechanisms". Progress notes were reviewed and there was no documentation found that staff contacted family either after or during angry outbursts to discuss successful past coping mechanisms. A progress note was reviewed and it indicates that resident #001's POA voiced concerns regarding the use of a specific medication and requested that the resident receive that medication , "only when (#001) absolutely needs or not all [sic] if possible". MARs and Progress notes for resident #001 were reviewed and resident #001 received the PRN medication on 7 different occasions after the POA requested resident #001 not receive it or receive it only the resident absolutely required it. There was no documentation found to support that staff had

attempted other techniques prior to the administration of the medication. The licensee failed to ensure 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. [s. 6. (5)]

3. The plan of care for resident #001 was reviewed and under the section titled "Nutritional Care", the following intervention was found, "NUTRITIONAL SUPPLEMENTS: Provide Resource 2.0, 120ml TID at meal times". An order from the home's registered dietitian, for "Resource 2.0 – 120 ml TID at 0800, 1200, 1700 hrs" for resident #001, was reviewed. Progress notes, MARs and "Food & Nourishment Daily Records" for resident #001, for 60 days were also reviewed. Documentation indicating that the resident either, received or refused the Resource 2.0 was found on the "Food & Nourishment Daily Record" only 14 of 138 times. No record of the resident receiving the Resource 2.0, on the MARs was found. 3 RPNs reported to inspector 106, that Resource 2.0 is administered by registered staff and is documented in the MARs. On November 23, 2012, staff member #S-102 reported that the resident regularly received the Resource 2.0 when they were working days. The licensee failed to ensure that the provision of the care set out in the plan of care is documented. [s. 6. (9) 1.]

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. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The plan of care for resident # 001 was reviewed, under the section titled "ADL Assistance", the following interventions were found, "TRANSFERRING: Independent - high risk for falls - encourage to use walker at all times", "Uses walker - remind to use at all times", "independent walking in room", "Independent walking in corridor" and "PERSONAL HYGIENE: Needs supervision, encouragement or cueing only to wash and groom self". The "Resident Observation & Monitoring Forms" and "Restraint Monitoring Forms" and progress notes for resident #001 were reviewed for September, October and November 2012. Documentation indicates that between September 30 and November 9, 2012, resident #001 was assessed by frontline staff as requiring staff assistance with transferring on 48 different shifts, required assistance with bed mobility on 36 different shifts and used a wheelchair as a mode of locomotion from October 11 until November 7, 2012. Documentation reviewed also indicates that from September 12 to November 9, 2012, resident #001 was assessed by frontline staff as requiring limited to total assistance requiring the physical assistance of at least one staff member on 65 different shifts. There is incongruity between the required level of care, identified in the plan of care for resident #001 and the documented level of care, assessed and provided to resident #001. The licensee failed to ensure that the plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. [s. 26. (3) 7.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The "Restraint Monitoring Forms" for resident #001 were reviewed for 28 days, the resident is recorded as having a restraint applied on 27 of those days. The plan of care for resident #001 was reviewed and no section in the plan of care regarding the use of a restraint was found. The licensee failed to ensure that if a resident is restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. [s. 31. (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 if a resident is restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. On November 23, 2012, inspector 106 received the home's "Zero Tolerance of Abuse and/or Neglect" and "Abuse of a resident" policies from staff member #S-100. Neither policy identified the training and retraining requirements for all staff regarding training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, or situations that may lead to abuse and neglect and how to avoid such situations. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff including: training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care; and situations that may lead to abuse and neglect and how to avoid such situation. [s. 96. (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff including: training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care; and situations that may lead to abuse and neglect and how to avoid such situation, to be implemented voluntarily.

WN #7: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The doctor's orders for resident #001 were reviewed, an order for a medication twice a day (bid) orally (po)/intramuscularly (IM) as required (prn), was found. A progress note was reviewed and it identifies that the above medication was to be given bid po prn or bid IM prn. The MARs and Progress notes for resident #001 were reviewed and it was found that on one day the resident received the medication three times and on another day received the medication four times. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, in regards to psychotropic medications, to be implemented voluntarily.

WN #8: 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. On November 23, 2012, during an interview and recorded during the original complaint intake, the complainant voiced concerns that they felt resident #001 was over medicated while in the home. MARs and progress notes for resident #001 were reviewed; the resident is documented as receiving a psychotropic medication PRN, 42 times. On five separate occasions, resident #001 received a PRN psychotropic medication; staff did not document the resident's response and the effectiveness of the drug. On four separate occasions, the resident is documented as receiving a PRN psychotropic medication; the staff only recorded if the medication was effective however, did not record the resident's response to the medication. The licensee failed to 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. [s. 134. (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, 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, to be implemented voluntarily.

Issued on this 1st day of March, 2013

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