Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 6, 2014	2014_320576_0011	S-000294-14	Resident Quality Inspection

Licensee/Titulaire de permis

SMOOTH ROCK FALLS HOSPITAL
107 KELLY ROAD, P.O. BOX 219, SMOOTH ROCK FALLS, ON, P0L-2B0

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

SMOOTH ROCK FALLS HOSPITAL
107 KELLY ROAD, P.O. BOX 219, SMOOTH ROCK FALLS, ON, P0L-2B0

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

MARSHA RIVERS (576), TIFFANY BOUCHER (543)

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): July 15, 16, 17, 18, 21, 22, 23, 24, 2014.

This inspection was conducted concurrently with Complaint Inspection #2014_376594_0007 and Critical Incident System Inspection #2014_376594_0006.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Chief Nursing Officer, the Manager of the Long-term Care Unit, the Activity Coordinator, registered practical nurses (RPNs), personal support workers (PSWs), housekeeping staff, residents, and family members of residents.

During the course of the inspection, the inspector(s) conducted a daily walk-through of the home, made direct observations of the delivery of care and services to residents, reviewed resident health care records, reviewed various policies and procedures, reviewed staff training records, and reviewed the package of information provided to residents and their families upon admission to the home.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with 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. On July 22, 2014 at 1000h, Inspector #576 observed that while completing a medication pass, the RPN left the medication cart unattended in the hallway outside of a resident's room. The medication cart was not locked and the Inspector was able to open the drawers of the cart that contained resident medications. On July 24, 2014, Inspector #543 observed that the medication cart was left unattended in the hallway outside of a resident's room. The Manager of the Long-term Care Unit confirmed that the lock on the medication cart is broken and the cart cannot be locked.

The licensee failed to ensure that drugs were stored in an area or a medication cart that is secure and locked. [s. 129. (1) (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. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. Inspector #543 spoke with the Manager of the Long-term Care Unit who stated that the home utilizes a Dispill dispensing package for all resident medications. These packages are kept in the medication cart in the medication room. The medication room locks using a pin code access. The Manager confirmed that Registered Nurses (RNs), RPNs and housekeeping have access to the medication room. This was confirmed by two RPNs who work on the unit. The Manager also confirmed that the lock on the medication cart is broken and the cart cannot be locked.

The licensee failed to ensure that access to areas where drugs are stored was restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator. [s. 130. 2.]

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 LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

Findings/Faits saillants :

1. Inspector #576 conducted interviews with staff #100 and staff #101 who stated that they have not received any training in the area of restraining of residents. Inspector requested records of staff education or training in the area of restraints and the home was unable to produce any records. The Manager of the Long-term Care Unit confirmed that staff are required to read the home's policies related to the restraining of residents however the home has not provided any training to direct care staff in the area of restraining of residents.

The licensee failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training at the time of orientation and at annual intervals thereafter as required, on how to minimize the restraining of residents, and where restraining is necessary, how to do so in accordance with the Act and the regulations. [s. 76. (1)]

2. Inspector #576 conducted interviews with staff #100 and staff #101 who stated that they have not received any training in the area of falls prevention and management. Inspector #594 requested records of staff education training in the area of falls prevention and management and the home was unable to produce any records. The Manager of the Long-term Care Unit confirmed that the home has not provided any training to direct care staff in the area of falls prevention and management.

The licensee failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training at the time of orientation and at annual intervals thereafter as required, in the area of falls prevention and management. [s. 76. (1)]

3. Inspector #576 conducted interviews with staff #100 and staff #101 who stated that they have not received any training in the area of continence care and bowel management. Inspector #543 requested records of staff education or training in the area of continence care and bowel management and the home was unable to produce any records. The Manager of the Long-term Care Unit confirmed that the home has not provided any training or education in the last 12 months.

The licensee failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training at the time of orientation and at annual intervals thereafter as required, in the area of continence care and bowel management. [s. 76. (1)]

4. Inspector #576 conducted interviews with staff #100 and staff #101 who stated that they have not received any training in the area of skin and wound care. Inspector #543 requested records of staff education or training in the area of skin and wound care the home was unable to produce any records. The Manager of the Long-term Care Unit confirmed that the home has not provided any training or education in the last 12 months.

The licensee failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training at the time of orientation and at annual intervals thereafter as required, in the area of skin and wound care. [s. 76. (1)]

5. Inspector #543 spoke with Manager of the Long-term Care Unit regarding education, training or retraining for responsive behaviours. The Manager confirmed that the home has not offered any education or training sessions in the last 12 months. The Manager stated that Gentle Persuasion Approach (GPA) training is usually done every spring but was not done in the last 12 months. The last time training sessions were provided was in the year 2012.

The licensee failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training at the time of orientation and at annual intervals thereafter as required, in the area of responsive behaviours. [s. 76. (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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. Inspector #543 reviewed resident #1943's most recent RAI/MDS assessment. This assessment identified a stage 1 ulcer, which is described as any lesion caused by pressure resulting in damage to underlying tissue. The Inspector reviewed this resident's health care record for skin assessments, no assessments were identified. The Inspector reviewed this resident's printed Care Plan. The Care Plan indicated that this resident will maintain a good skin integrity and wound free. This resident's Care Plan does not identify the stage 1 ulcer noted in the RAI/MDS assessment. Staff #100 confirmed that staff access the printed Care Plan kept in a binder at the nurses' station for plan of care information.

The licensee failed to ensure that the plan of care set out clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. Inspector #576 reviewed health care records for resident #1943 for the period of January 1, 2014 to July 23, 2014. Inspector noted that during this period, 5 Post Falls Assessments were completed. The action plans documented in the Post Falls Assessments identified falls prevention interventions including keeping floor mats at the bedside and the bed at its lowest position. Staff #101 stated that after each fall, registered staff are to update the resident's Care Plan to include the falls prevention interventions identified in the Post Falls Assessment. Staff #100 confirmed that staff access the printed Care Plan kept in a binder at the nurses' station for plan of care information. Inspector reviewed the printed Care Plan for resident #1943 and the Care Plan does not provide the falls prevention interventions identified in the Post Falls Assessment action plans, including keeping floor mats at the bedside and the bed at its lowest position. On July 23, 2014, Inspector observed resident #1943 in bed

and noted that no floor mats were at the bedside and the bed was not in the lowest position.

The licensee failed to ensure that the plan of care set out clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. Inspector #576 reviewed health care records for resident #1941 for the period of January 1, 2014 to July 23, 2014. Inspector noted that during this period, 3 Post Falls Assessments were completed. The action plans documented in the Post Falls Assessments identified falls prevention interventions including placing the call bell within the reach of the resident. Staff #101 stated that after each fall, registered staff are to update the resident's Care Plan to include the falls prevention interventions identified in the Post Falls Assessment. Staff #100 stated that falls prevention interventions for resident #1941 include keeping the bed in its lowest position, placing the call bell within the reach of the resident, and using a mechanical lift for transfers. Staff #100 also stated that staff access the printed Care Plan kept in a binder at the nurses' station for plan of care information. Inspector reviewed the printed Care Plan for resident #1941 and the Care Plan does not provide the falls prevention interventions identified in the Post Falls Assessment action plans, including placing the call bed within the reach of the resident. The Care Plan also does not include other falls prevention interventions identified by staff #100, including keeping the bed in its lowest position.

On July 23, 2014, Inspector #576 observed resident #1941 sitting in a wheelchair and on July 24, 2014, Inspector observed a walker in this resident's room. Inspector spoke with this resident who stated that he/she has been using the wheelchair to ambulate since a recent fall and that previous to this, he/she used a walker to ambulate. Inspector reviewed the printed Care plan for resident #1941. The Care Plan states that the resident is independent for walking and does not indicate the use of any mobility aides, such as a wheelchair or walker. Staff #101 stated that resident #1941 has been using a wheelchair since his/her last fall and confirmed that the Care Plan does not set out clear direction with respect to mobility and locomotion.

The licensee failed to ensure that the plan of care set out clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

4. Inspector #576 reviewed health care records for resident #0001 for the period of January 1, 2014 to July 23, 2014. Inspector noted that under the manager

assessment and follow-up section in the Post Falls Assessment for a specific fall, it is documented that a discussion with family and the Long-term Care Unit Manager was held following this fall and that a list of actions was put together to try to decrease fall incidents. Inspector reviewed the progress note which described this discussion. Actions listed in this progress note to decrease this resident's risk of falls included, but were not limited to, positioning the resident's bed at a proper height for him/her to be able to get up easily without causing further injury, placing blue mattresses on the floor beside the resident's bed at night, and placing the resident's walker further away from his/her bed at night to prevent him/her from trying to get up.
Staff #100 confirmed that staff access the printed Care Plan kept in a binder at the nurses' station for plan of care information. Inspector reviewed the printed Care Plan for resident #0001 and noted that the Care Plan was last updated on April 19, 2014 and was not updated to include the falls prevention interventions identified in the progress note. Specifically, the Care Plan does not indicate that the resident's bed is to positioned at a proper height for him/her to be able to get up easily without causing further injury, that blue mattresses are to be placed on the floor beside the resident's bed at night, and that the resident's walker to be placed away from him/her bed at night to prevent him/her from trying to get up.

The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident. [s. 6. (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 the plan of care sets out clear direction to staff and others who provide direct care to residents #1943, #1941, and #0001, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. On July 15, 2014 and July 16, 2014, Inspector #576 conducted a walk-through of the Long-term Care Unit and observed all resident rooms. Inspector noted that the windows in 20/20 (100%) of resident rooms had the capacity to open fully to the outdoors. Inspector #543 audited 6 resident rooms and confirmed that the windows in 6 out of the 6 resident rooms did fully open to the outside and could be opened more than 15 centimetres.

The licensee failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres. [s. 16.]

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 every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. Inspector #576 reviewed minutes from Residents' Council meetings that were held during the period of January 1, 2013 to July 23, 2014. Inspector noted that the meeting minutes did not indicate that the meal and snack times had been reviewed by the Residents' Council. The Vice-President of the Residents' Council and the Dietary Supervisor, who both regularly attend Residents' Council meetings, confirmed that meal and snack times have not been reviewed by the Residents' Council.

The licensee failed to ensure that the home's dining and snack service included a review of meal and snack times by the Residents' Council. [s. 73. (1) 2.]

2. On July 22, 2014, Inspector #576 observed lunch dining service and noted that resident #1943 was not present in the dining room and had been served a lunch tray to eat in his/her room. Inspector observed resident #1943 in his/her room between 1200h to 1230h and did not observe any staff entering this resident's room to monitor him/her after being served a lunch tray. Inspector noted that while the resident did not consume food or beverages during this period, the meal tray was within the reach of the resident and the resident was laying in bed in a supine position with the head of the bed not elevated.
Staff #100 confirmed that staff access the printed Care Plan kept in a binder at the nurses' station for plan of care information. The printed Care Plan for resident #1943 states that this resident refuses to have the head of the bed up and that the resident and family are aware of the increased risk of choking. The Care Plan also directs staff to provide supervision for all meals and snacks. Staff #102 confirmed that resident #1943 is served all meals in his/her room, refuses to raise the head of the bed up to a safe eating position which puts this resident at an increased risk of choking, and that staff do not monitor this resident during meals and snacks.

The licensee failed to ensure that the home's dining and snack service included monitoring of all residents during meals. [s. 73. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes review of meal and snack times by the Residents' Council and monitoring of all residents during meals, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Inspector #543 reviewed resident #1941's nursing progress notes between the period of January 1, 2014 to July 23, 2014. During this period, resident 1941 had a fall and was transferred to the emergency department. As a result of the fall, this resident sustained laceration and required sutures. Inspector #543 reviewed the Critical Incident Reports submitted to the Director by the home and confirmed that this incident was not reported to the Director.

The licensee failed to ensure that the Director was informed, no later than one business day after the occurrence of the incident, of an incident that caused an injury to a resident for which the resident was taken to the hospital and that resulted in a significant change in the resident's health status. [s. 107. (3) 4.]

2. Inspector #576 reviewed a Critical Incident Report and health care records for resident #0001. On May 24, 2014, resident #0001 had a fall and sustained a fracture. Following the fall, the resident was taken to the diagnostic imaging department in the adjoined hospital for x-rays and then transferred to the in-patient unit at the hospital for palliative care. The resident subsequently passed away in hospital. Inspector reviewed the Critical Incident Reports submitted by the home and confirmed that this incident was reported to the Director 11 days after the incident occurred.

The licensee failed to ensure that the Director was informed, no later than one business day after the occurrence of the incident, of an incident that caused an injury to a resident for which the resident was taken to the hospital and that resulted in a significant change in the resident's health status. [s. 107. (3) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is informed of all incidents that cause an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health status, no later than one business day after the occurrence of the incident, to be implemented voluntarily.

WN #8: 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. Inspector #576 reviewed the home's policies related to the restraining of residents. Inspector noted that the date of the last revision noted on these policies all exceeded one year. The policy titled "Use of Restraints, #VII-415"" was last revised June 2002, the policy titled "Documenting the Use of Restraints" was last revised January 2009, and the policy titled "Guideline for Restraint Record" was last revised January 2009. The Manager of the Long-term Care Unit confirmed that the home's policies related to the restraining of residents are not current and have not been evaluated annually.

The licensee failed to ensure that at lease once every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to minimize the restraining of residents. [s. 113. (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 at least once every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to minimize the restraining of residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. Inspectors #543 and #576 spoke with Manager of the Long-term Care Unit regarding drug destruction and disposal. This staff stated to Inspector #576 that the home discards all medications (including narcotics and non-narcotics) in sharps containers that are kept on the medication cart and in the hospital's pharmacy room. When full, the sharps containers are sealed and stored in a locked room until they are picked up by a company that destroys the hospital's biohazardous waste. This staff also confirmed to Inspector #543 that the home does not alter or denature any of the medications that they are destroying.

The licensee failed to ensure that when a drug was destroyed, the drug was altered or denatured to such an extent that its consumption is rendered impossible or improbable. [s. 136. (6)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

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).

Findings/Faits saillants :

1. Inspector #543 reviewed the home's Infection Control Program, including the following policies:
- Purpose and Goals of Infection Control Program (IPAC-Purpose and Goals-JUL10), last reviewed July 2010;
- Hand Hygiene (IPAC-Hand Hygiene-SEP10), last reviewed December 2012;
- Tuberculosis Testing for Residents of Long Term Care Unit (VI-20), last reviewed January 1998; and
- Immunizations (VI-35), last reviewed January 1995.
Inspector spoke with the lead for the Infection Control Program who confirmed that the above mentioned policies are the policies being utilized by staff. None of the above mentioned policies have been evaluated and updated annually.

The licensee failed to ensure that the infection prevention and control program was evaluated and updated at least annually. [s. 229. (2) (d)]

2. Inspector #543 reviewed 3 census sample residents' immunization histories. The Inspector identified a discrepancy in compliance with the home's policy "Tuberculosis Testing for Residents of Long Term Care Unit (VI-20)". This policy stated that it is the policy of Smooth Rock Falls Hospital that a TB skin test be performed on new residents within 14 days of admission. Therefore the Inspector randomly chose a total of 10 census sample residents including the 3 initial residents. The Inspector reviewed their TB screening status and identified that 7 out of the 10 residents did not receive TB screening within 14 days of admission to the home.

The licensee failed to ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission. [s. 229. (10) 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 infection prevention and control program is evaluated and updated at least annually and that each resident is screened for tuberculosis (TB) within 14 days of admission, to be implemented voluntarily.

WN #11: 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. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. Inspector #576 reviewed the health care records for resident #0817 for the period of May 9, 2014 to July 24, 2014. During this period, the resident's weight was measured two times and the resident had a weight loss of 6kg (10.4%). Inspector noted that during this period the resident required clinical interventions. The resident was not reassessed by a Registered Dietitian following the change in weight and health condition.

The licensee failed to ensure that a registered dietitian who is a member of the staff of the home completes a nutritional assessment for all residents whenever there is a significant change in a resident's health condition and assesses the residents nutritional status, including height, weight and any risks related to nutrition care. [s. 26. (4) (a),s. 26. (4) (b)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. Inspector #576 reviewed the home's policy "Dental Care" dated February 1994. The policy states that "a dental assessment, preventative services (scaling and cleaning, and an assessment to ensure that dentures are properly fitted) shall be offered annually or as required by qualified dental personnel, on a fee-for-service basis". The Manager of the Long-term Care Unit confirmed that in the past, a dentist came to the home to provide dental assessments and preventative services to residents in the home, however this service has not been offered to residents in the home for approximately 5 years.

The licensee failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. [s. 34. (1) (c)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and O. Reg. 79/10, s. 48 (2).
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Findings/Faits saillants :

1. Inspector #543 requested copies of assessment and reassessment instruments used in conjunction with the home's Continence Care and Bowel Management Program. No documents were provided. The Inspector #543 spoke with the Manager of the Long-term Care Unit who confirmed that the Continence Care and Bowel Management program does not have reassessment instruments and that the home utilizes the RAI/MDS assessment for this purpose. The Inspector spoke with a RPN on the unit who confirmed that no assessment or reassessment tools are used, that residents are either continent or incontinent when then are admitted to the home.

The licensee failed to ensure that the Continence Care and Bowel Management Program provides for assessment and reassessment instruments. [s. 48. (2) (b)]

2. Inspector #543 requested copies of the home's skin assessment instruments or tools. No documents were provided. The Inspector spoke with the Manager of the Long-term Care Unit who confirmed that the Skin Care and Wound Care Programs do not have assessment or reassessment instruments. The home utilizes the RAI/MDS assessment for this purpose. The Inspector spoke with a RPN on the unit who confirmed that staff do not perform skin assessment utilizing an instrument. The staff will observe the skin integrity or wound (if wound is present) and document findings in nursing notes, if there is any change in condition the unit Manager will be notified for further assessment.

The licensee failed to ensure that the home's Skin and Wound Program provides for assessment and reassessment instruments. [s. 48. (2) (b)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

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. Inspector #543 reviewed the home's Policy/Program titled "Behaviour Risk Assessment (NUR-LTC Behaviour Risk Assessment)" last reviewed January 2009. The Inspector identified that this policy/program does not have written protocols related to screening, assessments and reassessments. Inspector spoke with the Manager of the Long-term Care Unit who confirmed that the policy/program titled "Behaviour Risk Assessment" is the policy that staff refer to, and that this policy is in fact the home's Responsive Behaviours Program Policy.

The licensee failed to ensure that the home's Responsive Behaviours program includes written approaches to care, including screening protocols, assessments and reassessments. [s. 53. (1) 1.]

2. Inspector #543 reviewed the home's Policy/Program "Behaviour Risk Assessment (NUR-LTC Behaviour Risk Assessment)" last reviewed January 2009. The Inspector identified that this policy/program does not have written protocols for referrals to specialized resources. Inspector spoke with the Manager of the Long-term Care Unit who confirmed that the policy "Behaviour Risk Assessment (NUR-LTC Behaviour Risk Assessment)" is the policy that staff refer to, and that this policy is in fact the home's Responsive Behaviours Program Policy.

The licensee failed to ensure that the home's Responsive Behaviours program includes written protocols for referrals to specialized resources where required. [s. 53. (1) 4.]

3. Inspector #543 reviewed the home's Policy/Program "Behaviour Risk Assessment (NUR-LTC Behaviour Risk Assessment)" last reviewed January 2009. The Inspector identified that no annual evaluation is being done and the policy/program has not been updated since January 2009. Inspector spoke with the Manager of the Long-term Care Unit who confirmed that the policy "Behaviour Risk Assessment (NUR-LTC Behaviour Risk Assessment)" is the policy that staff refer to, and that this policy is in fact the home's Responsive Behaviours Program Policy.

The licensee failed to ensure that the home's Responsive Behaviours program was evaluated and updated at least annually. [s. 53. (3) (b)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 56. Residents' Council

Specifically failed to comply with the following:

s. 56. (2) Only residents of the long-term care home may be a member of the Residents' Council. 2007, c. 8, s. 56 (2)

Findings/Faits saillants :

1. Inspector #576 reviewed the home's policy "Resident Council" and the policy states that "family member or residents friends are welcome to attend Residents' Council as they are the voice of the resident who cannot speak for themselves". The Vice-President of the Residents' Council stated that family members regularly attend Residents' Council meetings. The Manager of the Long-term Care Unit stated that family members are encouraged by staff to attend Residents' Council meetings and do attend meetings. The Activity Coordinator confirmed that at least 3 family members attend most Residents' Council meetings and other family members and persons of importance to residents attend the meetings on an ad hoc basis.

The licensee failed to ensure that only residents of the long-term care home may be members of the Residents' Council. [s. 56. (2)]

WN #16: 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. Inspector #576 reviewed the home's policy titled "Resident Council" and noted that the policy states "suggestions and complaints from the resident council shall be documented, investigated and responded to in writing by the administrator of the facility within 21 days". Inspector noted that the time-frame specified in the home's policy for responding in writing to concerns or recommendations made by the Resident's Council is not consistent with the time-frame specified in the Act, which requires that the home responds in writing to the Residents' Council within 10 days of receiving the advice. Inspector requested the home's written responses to the Residents' Council and the home was unable to produce any documentation.

The licensee failed to ensure that the home responds in writing to the Residents' Council within 10 days of receiving the advice. [s. 57. (2)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 58. Residents' Council assistant

Specifically failed to comply with the following:

s. 58. (1) Every licensee of a long-term care home shall appoint a Residents' Council assistant who is acceptable to that Council to assist the Residents' Council. 2007, c. 8, s. 58. (1).

Findings/Faits saillants :

1. Inspector #576 reviewed the home's policy titled "Resident Council" and the policy states the following:
-monthly meetings with the Activity Coordinator, Long-term Care Manager, Dietary Manager and residents will be held in the Long-term Care dining room every last Thursday of each month;
-a minimum of seven residents is required for a meeting to be held;
-any meeting can be cancelled at the discretion of the Long-term Care Manager or Activity Coordinator; and
-the Long-term Care Manager will act as recording secretary and minutes.
Inspector reviewed the minutes of Residents' Council meetings held during the period of January 1, 2013 to July 24, 2014 and noted that the agendas consisted of updates provided by the management staff in attendance. The Manager of the Long-term Care Unit confirmed that management of the home, including this staff, the Dietary Supervisor and the Activity Coordinator, arrange, set the agenda, attend, facilitate, and keep minutes for all Residents' Council meetings. Inspector noted that the management of the home runs the Residents' Council and that the home has appointed 3 management staff to sit on the Council.

The licensee failed to appoint an assistant to the Residents' Council to assist the Council and who is acceptable to the Council. [s. 58. (1)]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. On July 15, 2014, Inspector #576 conducted a walk-through of the Long-term Care Unit and was unable to locate minutes of the Family Council meetings or any postings advising family members and persons of importance to residents of their right to establish a Family Council. The Manager of the Long-term Care Unit confirmed that the home does not have a Family Council and stated that for the last 3 years, the home has not taken any actions, including convening semi-annual meetings, to advise families and persons of importance to residents of their right to establish a Family Council.

The licensee failed to ensure that on an ongoing basis, residents' families and persons of importance to residents are advised of the right to establish a Family Council and failed to convene semi-annual meetings to advise such persons of the right to establish a Family Council. [s. 59. (7)]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 65. No interference by licensee
A licensee of a long-term care home,
(a) shall not interfere with the meetings or operation of the Residents' Council or the Family Council;
(b) shall not prevent a member of the Residents' Council or Family Council from entering the long-term care home to attend a meeting of the Council or to perform any functions as a member of the Council and shall not otherwise hinder, obstruct or interfere with such a member carrying out those functions;
(c) shall not prevent a Residents' Council assistant or a Family Council assistant from entering the long-term care home to carry out his or her duties or otherwise hinder, obstruct or interfere with such an assistant carrying out those duties; and
(d) shall ensure that no staff member, including the Administrator or other person involved in the management or operation of the home, does anything that the licensee is forbidden to do under clauses (a) to (c). 2007, c. 8, s. 65.

Findings/Faits saillants :

1. Inspector #576 reviewed the home's policy titled "Resident Council" and the policy states that meetings will be held every last Thursday of each month and that any meeting can be cancelled at the discretion of the Manager of the Long-term Care unit or the Activities Coordinator. Inspector reviewed the minutes from Residents' Council meetings held during the period of January 1, 2013 to July 23, 2014 and noted that 6 out of 12 scheduled meetings were cancelled in 2013 and that 4 out of 6 scheduled meetings were cancelled in 2014. The Vice-President of the Residents' Council confirmed that the Manager of the Long-term Care Unit, the Activities Coordinator, and the Dietary Supervisor organize, attend, facilitate, and record minutes for all Residents' Council meetings. Council meetings are to be held monthly however if there aren't enough residents in attendance or if one of these staff are unable to attend, then the meetings are cancelled by staff.

The licensee failed to ensure that the meetings or operation of the Residents' Council are not interfered with. [s. 65. (a),s. 65. (b),s. 65. (c),s. 65. (d)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(a) is a minimum of 21 days in duration; O. Reg. 79/10, s. 71 (1).
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks; O. Reg. 79/10, s. 71 (1).
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).
(d) includes alternative beverage choices at meals and snacks; O. Reg. 79/10, s. 71 (1).
(e) is approved by a registered dietitian who is a member of the staff of the home; O. Reg. 79/10, s. 71 (1).
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).
(g) is reviewed and updated at least annually. O. Reg. 79/10, s. 71 (1).

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(d) includes alternative beverage choices at meals and snacks; O. Reg. 79/10, s. 71 (1).

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

Findings/Faits saillants :

1. Inspector #576 reviewed the home's snack menu cycle. Inspector noted that the snack menu is dated January 5, 2012, is only 7 days in duration, and only identifies the planned menu for residents on a regular diet for afternoon and evening snacks. The Dietary Supervisor confirmed that the home's snack menu was last updated January 5, 2012, is only 7 days in duration, and does not include menus for therapeutic and texture modified diets.

The licensee failed to ensure that the home's menu cycle was a minimum of 21 days in duration; included menus for regular, therapeutic and texture modified diets for snacks; and was reviewed and updated at least annually as required in section 71(1)(a)(b)(g) to the Act. [s. 71. (1)]

2. On July 16, 2014, residents #1930, #1162, and #8237 reported to Inspector #576

that they are not offered a between meal beverage in the morning. On July 23, 2014 and July 24, 2014 during the period of 1030h to 1100h, Inspector #576 conducted a walk-through of the Long-term Care Unit. Inspector did not observe a nutrition cart being circulated or residents being offered a beverage however Inspector noted that some resident's had a glass of water at their bedside. Staff #100 and staff #101 confirmed that residents are offered a glass of water but are not offered a choice of beverage between breakfast and lunch meals.

The licensee failed to ensure that the home's menu cycle included an alternative beverage choice at snacks. [s. 71. (1) (d)]

3. On July 15, 2014, Inspector #576 observed supper dining service. Inspector noted that the staff assisting in the dining room served residents a pre-poured juice that had been labelled with resident room numbers and that residents were not offered a choice of juice. The Dietary Supervisor confirmed that juices are pre-poured by staff in the kitchen and residents are not offered a choice of juice during meals.

The licensee failed to ensure that the home's menu cycle included an alternative beverage choice at meals. [s. 71. (1) (d)]

4. On July 15, 2014, Inspector #576 observed supper dining service. The posted weekly and daily menus indicated that 2 choices of entrees and desserts were to be offered and available at this meal. Inspector noted that some residents were offered a choice of two entrees and desserts, and that only one entree and dessert option was served in pureed and minced textures. Staff #103 confirmed that only 1 entree and dessert option was prepared and offered in minced and pureed textures. The Dietary Supervisor stated that for approximately 10 years, only 1 option is prepared for entrees and desserts in pureed texture, and often, only one option is prepared for entrees and desserts in minced texture and therapeutic diets in all texture types.

The licensee failed to ensure that the planned menu items are offered and available at each meal. [s. 71. (4)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. On July 15, 2014, Inspector #576 observed supper dining service. The weekly menu posted outside the dining room and daily menu posted inside the dining room indicated that rice was to be served with the option 1 entree and no substitutions were noted on the menus. Inspector observed that mashed potatoes were served on minced and pureed texture plates instead of rice. Staff #103 confirmed that mashed potatoes were substituted for rice for pureed and minced texture types. The Dietary Supervisor stated that mashed potatoes are always substituted for the starch component of the entree at lunch and supper meals, except when the entree is pasta. Inspector reviewed the home's current menu cycle for meals and noted that the menu cycle does not indicate that mashed potatoes will be substituted.

The licensee failed to ensure that the food production system provided for communication to residents and staff of any menu substitutions. [s. 72. (2) (f)]

WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(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. 78 (2)
(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. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. Inspector #576 reviewed the package of information given to every resident and to the substitute decision-maker of the resident, if any, at the time the resident is admitted (admission package). The Inspector was unable to locate the home's policy to promote zero tolerance of abuse and neglect of residents. The Manager of the Long-term Care Unit confirmed that the home's admission package does not include

the home's policy to promote zero tolerance of abuse and neglect of residents.

The licensee failed to ensure that the package of information given to every resident and to the substitute decision-maker of the resident, if any, at the time the resident is admitted included the home's policy to promote zero tolerance of abuse and neglect of residents. [s. 78. (2) (c)]

2. Inspector #576 reviewed the home's admission package and was unable to locate an explanation of the duty to make mandatory reports related to incidents resulting in harm or risk of harm to a resident. The Manager of the Long-term Care Unit confirmed that the home's admission package does not include an explanation of the duty to make mandatory reports.

The licensee failed to ensure that the package of information given to every resident and to the substitute decision-maker of the resident, if any, at the time the resident is admitted included an explanation of the duty to make mandatory reports related to incidents resulting in harm or risk of harm to a resident. [s. 78. (2) (d)]

3. Inspector #576 reviewed the home's admission package and was unable to locate the home's policy to minimize the restraining of residents or information about how a copy of the policy to minimize the restraining of residents can be obtained. The Manager of the Long-term Care Unit confirmed that the home's admission package does not include the home's policy to minimize the restraining of residents or information about how a copy of the policy to minimize the restraining of residents can be obtained.

The licensee failed to ensure that the package of information given to every resident and to the substitute decision-maker of the resident, if any, at the time the resident is admitted included 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. [s. 78. (2) (g)]

4. Inspector #576 reviewed the home's admission package and was unable to locate an explanation of whistle-blowing protections related to retaliation. The Manager of the Long-term Care Unit confirmed that the home's admission package does not include an explanation of the whistle-blowing protections related to retaliation.

The licensee failed to ensure that the package of information given to every resident and to the substitute decision-maker of the resident, if any, at the time the resident is

admitted included an explanation of the protections afforded by section 26 of the Act. [s. 78. (2) (q)]

WN #23: 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).

Findings/Faits saillants :

1. On July 15, 2014, Inspector #576 conducted a walk-through of the Long-term Care Unit and was unable to locate a posted copy of the following documents:
-a mission statement;
-the home's policy to promote zero tolerance of abuse and neglect of residents;
-a procedure for initiating complaints to the licensee;
-notification of the home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained;
-the name and telephone number of the licensee;
-an explanation of evacuation procedures;
-the most recent minutes of the Residents' Council meetings; and
-an explanation of whistle-blowing protections afforded under section 26 to the Act.
On July 16, 2014, Inspector #576 and the Manager of the Long-term Care Unit conducted a walk-through of the unit and this staff confirmed that the above documents are not posted in a conspicuous and easily accessible location to residents.

The licensee failed to ensure that all of the required information specified in section 79(1)(3) to the Act was posted in the home, in a conspicuous and easily accessible location. [s. 79. (1)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 82. Attending physician or RN (EC)

Specifically failed to comply with the following:

s. 82. (1) Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,
(a) conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination; O. Reg. 79/10, s. 82 (1).
(b) attends regularly at the home to provide services, including assessments; and O. Reg. 79/10, s. 82 (1).
(c) participates in the provision of after-hours coverage and on-call coverage. O. Reg. 79/10, s. 82 (1).

Findings/Faits saillants :

1. Inspector #543 spoke with the Manager of the Long-term Care Unit who stated that 3 physicians oversee the physical examinations of the residents in the home, and that physical examinations are to be done on admission to the home and on a annual basis for all residents. Inspector reviewed the history of physical examinations for all the residents in the home and noted the following:
-5 out of the 20 residents did not receive a physical examination in the year 2012;
-2 out of the 20 residents did not receive a physical examination in the year 2013;
-2 out of the 20 residents who were admitted to the home in 2013 have not received a physical examination upon admission; and
-6 out of the 20 residents who were admitted to the home in 2014 have not received a physical examination upon admission.
The Manager of the Long-term Care unit confirmed that no annual physical examinations have been completed for the year 2014.

The licensee failed to ensure that either a physician or a registered nurse in the extended class, conducted a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produced a written report of the findings of the examination. [s. 82. (1)]

WN #25: 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. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. Inspector #576 was unable to locate the satisfaction surveys carried out by the home subsequent to September 2012, or the the results of these surveys. The Manager of the Long-term Unit confirmed that a satisfaction survey has not been carried out by the home since September 2012.

The licensee failed to ensure that, at least once in every year, a survey was taken of residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided by the home. [s. 85. (1)]

WN #26: 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. Inspector #543 spoke with the Chief Nursing Officer (CNO) who stated that the Hospital has an interdisciplinary Pharmacy Committee that meets quarterly. Inspector requested minutes from the meetings that are to occur quarterly and the CNO provided the Inspector with copies of the minutes from the meetings. Inspector noted that meetings were held on November 13, 2012, April 9, 2013 and November 1, 2013 and that the committee did not meet quarterly.

The licensee failed to ensure that an interdisciplinary team met 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. [s. 115. (1)]

Issued on this 8th day of September, 2014

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

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) :	MARSHA RIVERS (576), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2014_320576_0011
Log No. / Registre no:	S-000294-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 6, 2014
Licensee / Titulaire de permis :	SMOOTH ROCK FALLS HOSPITAL 107 KELLY ROAD, P.O. BOX 219, SMOOTH ROCK FALLS, ON, P0L-2B0
LTC Home / Foyer de SLD :	SMOOTH ROCK FALLS HOSPITAL 107 KELLY ROAD, P.O. BOX 219, SMOOTH ROCK FALLS, ON, P0L-2B0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	FABIEN HEBERT

To SMOOTH ROCK FALLS HOSPITAL, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that drugs are stored in an area or a medication cart that is secure and locked.

Grounds / Motifs :

1. On July 22, 2014 at 1000h, Inspector #576 observed that while completing a medication pass, the RPN left the medication cart unattended in the hallway outside of resident's room. The medication cart was not locked and the Inspector was able to open the drawers of the cart that contained resident medications. On July 24, 2014, Inspector #543 observed that the medication cart was left unattended in the hallway outside of a resident's room. The Manager of the Long-term Care Unit confirmed that the lock on the medication cart is broken and the cart cannot be locked.

The licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.
(543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 12, 2014

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. 130. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Order / Ordre :

The licensee shall ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator

Grounds / Motifs :

1. Inspector #543 spoke with the Manager of the Long-term Care Unit who stated that the home utilizes a Dispill dispensing package for all resident medications. These packages are kept in the medication cart in the medication room. The medication room locks using a pin code access. The Manager confirmed that Registered Nurses (RNs), RPNs and housekeeping have access to the medication room. This was confirmed by two RPNs who work on the unit. The Manager also confirmed that the lock on the medication cart is broken and the cart cannot be locked.

The licensee failed to ensure that access to areas where drugs are stored is restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator. (543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 12, 2014

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

Order / Ordre :

The home shall ensure that all staff receive the training as stated in section 76 of the LTCHA prior to performing their responsibilities and retraining at intervals also provided for in section 76 of the LTCHA.

Grounds / Motifs :

1. Inspector #543 spoke with Manager of the Long-term Care Unit regarding staff education, training or retraining for responsive behaviours. The Manager confirmed that the home has not offered any education or training sessions in the last 12 months. The Manager stated that Gentle Persuasion Approach (GPA) training is usually done every spring but was not done in the last 12 months. The last time training sessions were provided was in the year 2012.

The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training at the time of orientation and at annual intervals thereafter as required, in the area of responsive behaviours. (576)

2. Inspector #576 conducted interviews with staff #100 and staff #101 who stated that they have not received any training in the area of skin and wound care. Inspector #543 requested records of staff education or training in the area of skin and wound care the home was unable to produce any records. The Manager of the Long-term Care Unit confirmed that the home has not provided any training or education in the last 12 months.

The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training at the time of orientation and at annual intervals thereafter as required, in the area

of skin and wound care. (576)

3. Inspector #576 conducted interviews with staff #100 and staff #101 who stated that they have not received any training in the area of continence care and bowel management. Inspector #543 requested records of staff education or training in the area of continence care and bowel management and the home was unable to produce any records. The Manager of the Long-term Care Unit confirmed that the home has not provided any training or education in the last 12 months.

The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training at the time of orientation and at annual intervals thereafter as required, in the area of continence care and bowel management. (576)

4. Inspector #576 conducted interviews with staff #100 and staff #101 who stated that they have not received any training in the area of falls prevention and management. Inspector #594 requested records of staff education training in the area of falls prevention and management and the home was unable to produce any records. The Manager of the Long-term Care Unit confirmed that the home has not provided any training to direct care staff in the area of falls prevention and management.

The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training at the time of orientation and at annual intervals thereafter as required, in the area of falls prevention and management.
(576)

5. Inspector #576 conducted interviews with staff #100 and staff #101 who stated that they have not received any training in the area of restraining of residents. Inspector requested records of staff education or training in the area of restraints and the home was unable to produce any records. The Manager of the Long-term Care Unit confirmed that staff are required to read the home's policies related to the restraining of residents however the home has not provided any training to direct care staff in the area of restraining of residents.

The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training at

the time of orientation and at annual intervals thereafter as required, on how to minimize the restraining of residents, and where restraining is necessary, how to do so in accordance with the Act and the regulations. (576)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 07, 2014

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 6th day of September, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Marsha Rivers

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