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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 18, 2014	2014_282543_0025	S-000430-14	Resident Quality Inspection

Licensee/Titulaire de permis

ANSON GENERAL HOSPITAL
58 Anson Dr. IROQUOIS FALLS ON P0K 1E0

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

SOUTH CENTENNIAL MANOR
240 FYFE STREET IROQUOIS FALLS ON P0K 1E0

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

TIFFANY BOUCHER (543), JENNIFER LAURICELLA (542)

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): October 7th-17th, 2014

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Director of Support Services, Registered Dietician, Activation staff, RAI/MDS Coordinator,Dietary Aides, Residents, Families/visitors

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **16 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that,
(a) there is an organized program of housekeeping for the home; 2007, c. 8, s. 15 (1).
(b) there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents; and 2007, c. 8, s. 15 (1).
(c) there is an organized program of maintenance services for the home. 2007, c. 8, s. 15 (1).

Findings/Faits saillants :

1. Two previous compliance orders (CO) were issued with regards to the maintenance services related to s. 15 (1) of the Long-Term Care Homes Act, 2007. The first CO was issued on May 28th, 2013; inspection # 2013_138151_0017. The second CO was issued on October 24th, 2013; inspection # 2013_138151_0028.

Over the course of the inspection, Inspectors observed many areas of the home that require repair. On October 16th, 2014 Inspector #542 spoke with the Director of Support Services who stated that the home did follow-up with the previous orders left with regards to the Maintenance program. The Director of Support Services is aware that other areas of the home are in a state of repair.

The following areas were observed by Inspectors during the inspection:

SUNRISE-UNIT A

-the utility room: the baseboard flooring is lifting away from the wall
-tub room: some of the floor tiling is missing and the floor is lifting in some of the areas
-room 2: wear and tear in carpet in front of the window
-room 2: shared bathroom vanity is in disrepair and the wall around the vanity has the dry wall exposed
-room 4: vanity in bathroom with lots of wear and tear
- room 5: has a lingering urine odor in the resident's room and in the shared bathroom. The bathroom vanity has areas where the top surface layer is gone, exposing the chip board
-room 6: vanity in disrepair, front coming off chipboard exposed and band aids on corners of bathroom cupboard door
-room 8: vanity in disrepair, chipboard exposed
-room 9 vanity in disrepair
-room 11: vanity in disrepair

BLUEBIRD-UNIT B

-tub room, water damage to the flooring, stained under the tub
-room 3: bathroom has a strong lingering urine odor and the large stains on the flooring behind the toilet.
-room 11: shared bathroom vanity drawers are in disrepair, exposing the chip board

-room 13: vanity drawers chipboard exposed

SWEETPEA-UNIT C

-tub room: linoleum is bubbling
-room 6 strong smell of urine in bathroom
-room 8 strong smell of urine in bathroom
-room 11 hole in flooring of room
-room 14 ceiling above the bed large water marks, resident's family stated ceiling leaks a lot especially in the spring and the summer when it rains

The Inspectors' list of observations as listed above in no way represents a comprehensive audit of all home areas. These observations are evidential examples that the home continues to have maintenance issues that affect the safety of the residents.

The licensee has failed to ensure that there is an organized program of maintenance services for the home. [s. 15. (1) (c)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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).

Findings/Faits saillants :

1. On October 9th, 2014 Inspector #542 reviewed resident #728's health care records.

The care plan available to the staff did not indicate any nutritional interventions for this resident. On the dietary summary sheets located in the dining room it indicated that the resident was to receive Ensure supplement 120 cc four times per day at the medication pass, however the current Medication Administration Record indicated that the resident was to receive Resource 80 cc four times per day at the medication pass which is unclear.

The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to resident #728. [s. 6. (1) (c)]

2. Inspector #543 reviewed resident #001's health care records. These records identified that this resident had a fall in February, 2014 which resulted in a fractured hip. This resident returned to the home,had another fall; a post fall assessment was done which was a result of this resident attempting to get the the bathroom. Inspector was unable to determine the time of the fall as it was not documented on the Post Fall Assessment; nor was there any nursing progress note completed.

Inspector #543 reviewed resident #001's care plan, it was documented that a geri-chair with table top was put in effect in September, 2014 at the request of the family. The care plan does not identify clear direction to direct care staff specifically relating to interventions implemented to prevent this resident from falling. This care plan does not specifically outline how this device is applied, who is to apply the device, etc.

Inspector spoke with the RN on the unit who confirmed that resident #001's care plan is vague in terms of addressing fall concerns for this resident. This RN also confirmed that direct care staff rarely if ever refer to care plans to guide their care.

Inspector spoke with the DOC who confirmed that residents' care plans are weak and there is work that needs to be done with the care plans. Also, that the care plans are outdated on the unit and that the direct care staff do not refer to the care plan when providing care to the residents.

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

3. On October 9th, 2014 Inspector #542 reviewed resident #753's health care record. It was identified on the dietary summary sheet that is located in the dining rooms that this resident was on a minced texture diet. Inspector # 542 noted that there was no

nutritional/hydration information on the resident's care plan. On October 15th, 2014 Inspector #542 interviewed two PSW staff who stated that the resident receives a regular textured diet and is at risk for choking; which differs from what is stated on the care plan. The care plan also did not include the information with regards to the resident's bathing, bed mobility, dressing and personal hygiene interventions.

The licensee has failed to ensure that the plan of care sets out clear directions to staff and other who provide direct care to resident #753. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear to staff and others who provide direct care to all resident who reside in the home, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

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

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

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. Inspector #543 reviewed the home's records for annual Fall Prevention and Management Program training sign in sheets. These sheets identified that only 20/58 (35%) direct care staff received annual review of the Falls Prevention and Management Program.

The inspector spoke with the Learning and Development Program Lead who stated that the annual training requires staff to read and sign once they have reviewed the

policy/program. As well, a power point slide show is available to review.

The Inspector confirmed with the DOC that the annual review of policies/programs are not consistently being done.

Consequently, the licensee failed to ensure that direct care staff are provided with training in fall prevention and management. [s. 221. (1) 1.]

2. On October 16th, 2014 Inspector # 542 reviewed the policy and procedure-Minimizing Restraining of Residents and the training records pertaining to restraints and PASDs for all staff who apply physical devices or who monitor residents who are restrained. Inspector #542 was unable to locate any training records for 2013. Inspector #542 interviewed the DOC and The Learning and Development Program Lead, both of whom could not locate any training records for 2013.

The licensee has failed to ensure that training is provided to all staff who apply physical devices or who monitor residents restrained by a physical device. [s. 221. (1) 5.]

3. On October 16th, 2014 Inspector #542 reviewed the policy and procedure-Use of Personal Assistance Service Devices (PASDs) and the training records pertaining to PASDs for all staff who apply physical devices or who monitor residents who are restrained. Inspector #542 was unable to locate any training records for 2013. Inspector #542 interviewed the DOC and The Learning and Development Program Lead, both of whom could not locate any training records for 2013.

The licensee has failed to ensure that training is provided to all staff who apply PASDs or who monitor residents with PASDs. [s. 221. (1) 6.]

4. On October 16th, 2014 the Learning and Development Program Lead and the DOC provided the Inspectors with the annual training attendance sheets for 2013 for the direct care staff. Inspector # 542 reviewed the attendance sheets for the training provided on Prevention of Abuse, Neglect and Retaliation for 2013 and noted that 15/57 (26 %) of the staff who provide direct care to residents received the annual training during 2013.

The licensee has failed to ensure that all staff who provide direct are to residents, receive training relating to abuse recognition and prevention, annually or as determined by the licensee, based on the assessed training needs of the individual staff member. [s. 221. (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 all direct care staff are provided with training in Falls Prevention, Minimizing Restraints and the Prevention of Abuse and Neglect, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Inspector #543 spoke with the RPN regarding the Continence Care and Bowel Management Program in the home. She confirmed that there is a policy/program available for staff review, but in actuality the program is essentially not in effect or being consistently referred to by direct care staff.

The Inspector reviewed the home's Continence Care and Bowel Management Program. This program makes reference to tools and assessment instruments that were utilized with the home's old software program which are no longer available. The Inspector spoke with DOC who confirmed that the home is in the process of updating all their policies and making them available online for all staff, but at this time is not available.

Furthermore, the Inspector spoke with the Learning and development Program Lead who confirmed that staff are to review the home's policies/programs, that annual training consists of reading the policy/program and signing off that it has been completed. This lead also confirmed that staff are only "re-trained" when changes have been made to the policies/programs.

Inspector #543 also reviewed the home's records for annual Continence Care and Bowel Management training sign in sheets. This sheet identified that 23/59 (39%) direct care staff received annual review of the policy/program.

Consequently, the licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act. [s. 8. (1) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. On October 16th, 2014 Inspector #542 interviewed the Director of Care and the Director of Support Services who stated that the home does not currently assess the resident's bed systems, all potential zones of entrapment and the height and latch reliability of the bed rails. The Director of Support Services stated that they are working on developing a plan to assess the bed systems.

The licensee has failed to ensure that where bed rails are used, the residents are assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident. [s. 15. (1) (a)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. On October 8th, 2014 Inspector #542 observed resident #726 sitting in their wheel chair with a seat belt on and a specialty cushion to prevent them from sliding. On October 9th, 2014 Inspector #542 completed a health record review for resident #726. The most recent care plan accessible to the direct care staff did not contain any information with regards to the use of a PASD. On October 9th, 2014 Inspector #542 interviewed two separate registered staff, both could not locate any information on the resident's care plan specifically related to the use of the seat belt.

The licensee has failed to ensure that the PASD, used to assist resident #726 with a routine activity of living is included in their plan of care. [s. 33. (3)]

2. On October 8, 2014 Inspector #542 observed resident #728 in their wheel chair with a table top and seat belt in place. A health record review was conducted and Inspector # 542 was unable to locate a consent form for the use of the table top. On October 15th, 2014 Inspector #542 interviewed two separate registered staff and they were also unable to locate a consent for the use of the table top.

The licensee has failed to ensure that the use of the PASD has been consented by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. [s. 33. (4) 4.]

WN #7: 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 reviewed resident #727's health care record and was unable to locate any assessments or reassessments relating to Continence Care and Bowel Management.

The Inspector spoke with RPN/RAI Lead regarding the Continence Care and Bowel Management Program in the home. She confirmed that there is a policy/program available for staff review, but in actuality the program is essentially not in effect or being consistently referred to by direct care staff. She also confirmed that the home does not use a clinically appropriate assessment tool specifically designed to assess continence.

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

WN #8: 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. On October 16th, 2014 Inspector #542 interviewed the Resident Council President and was informed that the licensee does not respond in writing within 10 days of receiving concerns or recommendations from the Residents' Council. Inspector #542 also met with the Activation staff for the home (who was appointed as the Resident Council Assistant)who confirmed that the home has an informal process and does not respond in writing to the concerns or recommendations received from the Council. She also stated that the home generally responds at the next meeting that is generally held one month later.

The licensee has failed to ensure that they respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations. [s. 57. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On October 9th, 2014 Inspector #542 completed a health record review for resident #753 and was unable to locate an annual height. Inspector interviewed two separate registered staff who stated that the home does not complete an annual height on the residents and that it is only done on admission. On October 15th, 2014 Inspector #542 reviewed the licensee's policy titled "Nutrition" which indicates that resident's heights are recorded on admission.

The licensee has failed to ensure that all resident's heights are monitored and recorded annually. [s. 68. (2) (e) (ii)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. On October 9th, 2014 Inspector # 542 reviewed resident #728's health care records and identified that this resident had a change of over 5% of body weight from July 2014 to August 2014. Resident #728 was previously assessed as being a High Nutritional Risk according to the dietary summary sheets located in the dining room. Inspector #542 was unable to locate any interdisciplinary assessments related to the weight change. On October 16th, 2014 Inspector # 542 met with the Registered Dietitian (RD) who stated that she is behind in her assessments and that an assessment for this resident should have been completed.

The licensee has failed to ensure that residents with weight changes are assessed using an interdisciplinary approach and that actions are taken and outcomes are evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. On October 9th, 2014 Inspector # 542 completed a health record review for resident # 753. Inspector noted that the resident was diagnosed with multiple medical diagnoses and had previous skin integrity issues and was previously assessed as being a Moderate Nutritional Risk. It was documented that the resident had a weight decrease from August 2014 to September 2014. Inspector #542 could not locate that an assessment was completed other than an assessment from September 2013 by the RD. The RD was interviewed by the Inspector and stated that an assessment should have been completed and that she is behind on her assessments.

On October 16th, 2014, Inspector #542 reviewed resident #767's health care records which also indicated that they had a significant weight change and there was no documentation to support that an assessment was completed. This resident was previously assessed as being a High Nutritional Risk according to the Dietary Summary sheets located in the dining room.

The licensee has failed to ensure that residents with weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #11: 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).

Findings/Faits saillants :

1. The Resident Council President informed Inspector #542 that the licensee does not ensure that the meal and snack times are reviewed by the Resident Council. Inspector #542 interviewed the Resident Council Assistant who also verified that the licensee does not review the meal and snack times with the Residents' Council.

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. An interview with the Resident Council President was conducted on October 16th, 2014 by Inspector #542 and was informed that they have never seen or taken part in developing or carrying out the satisfaction survey. Inspector #542 also spoke with the Resident Council Assistant who verified that they do no participate in the development of the satisfaction survey, however they have discussed the results of previous surveys. Inspector #542 reviewed the past 3 months of Resident Council minutes which indicated that the survey results were discussed.

The licensee has failed to ensure that they seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

WN #13: 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. On October 16th, 2014 Inspector #542 reviewed the home's policy-Minimizing Restraining of Residents which indicated that a monthly analysis of the restraints is to be conducted by the Administrator, Director of Nursing and Registered Staff. The Inspector interviewed the RAI Coordinator and the Director of Care who stated that the home does not complete an analysis of the restraining of residents by use of a physical device on a monthly basis.

The licensee has failed to ensure that an analysis of the restraining of residents by use of a physical device is undertaken on a monthly basis. [s. 113. (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On October 14th, 2014-Inspector #543 reviewed the home's Medication Management Manual provided by the DOC. The Inspector was unable to locate a policy and procedure relating to safe storage of medication.

Inspector #543 spoke to the DOC about being unable to locate a policy relating to safe storage of medication. The DOC confirmed that the policy would be in the home's Medication Management Manual. When the Inspector informed the DOC that no policy in the manual refers to Safe Storage of Medication, the DOC agreed that in fact there is no policy.

Consequently, the licensee failed to ensure that written policies and protocols are developed for the medication management system to ensure accurate storage of all drugs used in the home. [s. 114. (2)]

WN #15: 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. On October 16th, 2014-Inspector #543 spoke with the DOC regarding the home's Pharmacy and Therapeutic committee. The DOC stated that the team meets quarterly.

The inspector requested the meeting minutes for the last 3 meetings, the DOC was unable to provide all minutes.The most recent minutes are dated May 27th, 2014. Other minutes provided were dated from the year 2012. The DOC stated that the next Pharmacy and Therapeutic committee meeting is scheduled for October 17th, 2014.

Consequently, the licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly. [s. 115. (1)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Throughout the course of the inspection, Inspectors #542 and #543 observed the medication/charting room door ajar. The Inspectors were in the home on October 7, 8, 9, 15 and 16th, 2014 on all days the medication room was observed to be accessible to RNs, RPNs, PSWs, activation worker as well as maintenance. The medication carts are kept in the medication room, at all times when not in use.

On October 8th, 2014- Inspector #542 spoke with the RN on the unit regarding the medication room in the home. The RN confirmed that all staff have access to the medication/charting room. The cupboard where the narcotics are kept is double locked, and the only staff member who has a key is the RN. The RN also confirmed that all the medications are stored in this room.

On October 15th, 2014, inspector #543 spoke with the RPN who confirmed that the medication/charting room is accessible to all staff (ie: activation, dietary, RNs, RPNs and PSWs).

Consequently, the licensee failed to ensure that drugs are stored in an area that is used exclusively for drugs and drug-related supplies and that is secure and locked. [s. 129. (1) (a)]

Issued on this 31st day of December, 2014

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	TIFFANY BOUCHER (543), JENNIFER LAURICELLA (542)
Inspection No. / No de l'inspection :	2014_282543_0025
Log No. / Registre no:	S-000430-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 18, 2014
Licensee / Titulaire de permis :	ANSON GENERAL HOSPITAL 58 Anson Dr., IROQUOIS FALLS, ON, P0K-1E0
LTC Home / Foyer de SLD :	SOUTH CENTENNIAL MANOR 240 FYFE STREET, IROQUOIS FALLS, ON, P0K-1E0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Diane Stringer

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2013_138151_0028, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (1) Every licensee of a long-term care home shall ensure that,
(a) there is an organized program of housekeeping for the home;
(b) there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents; and
(c) there is an organized program of maintenance services for the home. 2007, c. 8, s. 15 (1).

Order / Ordre :

The home shall develop, submit and implement a plan to ensure there is an organized program of maintenance services for the home that will provide for the safety and comfort of the residents; and ensuring that the home is maintained in a good state of repair. The plan will address issues identified in the grounds for the order and will include a detailed description of the measures that will be taken to address and sustain the maintenance of the home on an on-going basis.

This plan shall be submitted in writing to Tiffany Boucher, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705-564-3133 or email: tiffany.boucher@ontario.ca. This plan must be submitted by January 12, 2015 and fully complied with by March 1st, 2015.

Grounds / Motifs :

1. Two previous compliance orders (CO) were issued with regards to the maintenance services related to s. 15 (1) of the Long-Term Care Homes Act, 2007. The first CO was issued on May 28th, 2013; inspection # 2013_138151_0017. The second CO was issued on October 24th, 2013; inspection # 2013_138151_0028.

Over the course of the inspection, Inspectors observed many areas of the home that require repair. On October 16th, 2014 Inspector # 542 spoke with the Director of Support Services who stated that the home did follow-up with the previous order left with regards to the Maintenance program. The Director of Support Services is aware that other areas of the home are in a state of repair.

The following areas were observed by Inspectors during the inspection:

SUNRISE-UNIT A

-the utility room: the baseboard flooring is lifting away from the wall
-tub room: some of the floor tiling is missing and the floor is lifting in some of the areas
-room 2: wear and tear in carpet in front of the window
-room 2: shared bathroom vanity is in disrepair and the wall around the vanity has the dry wall exposed
-room 4: vanity in bathroom with lots of wear and tear
- room 5: has a lingering urine odor in the resident's room and in the shared bathroom. The bathroom vanity has areas where the top surface layer is gone, exposing the chip board
-room 6: vanity in disrepair, front coming off chipboard exposed and band aids on corners of bathroom cupboard door
-room 8: vanity in disrepair, chipboard exposed -room 9 vanity in disrepair
-room 11: vanity in disrepair

BLUEBIRD-UNIT B

-tub room, water damage to the flooring, stained under the tub
-room 3: bathroom has a strong lingering urine odor and the large stains on the flooring behind the toilet.
-room 11: hole in the flooring, shared bathroom vanity drawers are in disrepair, exposing the chip board
-room 13: vanity drawers chipboard exposed

SWEETPEA-UNIT C

-tub room: linoleum is bubbling
-room 6 strong smell of urine in bathroom

-room 8 strong smell of urine in bathroom
-room 14 ceiling above the bed large water marks, resident's family stated ceiling leaks a lot especially in the spring and the summer when it rains

The Inspectors' list of observations as listed above in no way represents a comprehensive audit of all home areas. These observations are evidential examples that continues to have maintenance issues that affect the safety of the residents.

The licensee has failed to ensure that there is an organized program of maintenance services for the home. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 01, 2015

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 18th day of December, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Tiffany Boucher

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