Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MONIQUE BERGER (151), LAUREN TENHUNEN (196), MARGOT BURNS-PROUTY (106), MELISSA CHISHOLM (188)
Inspection No. / No de l'inspection :	2012_138151_0013
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Date of Inspection / Date de l'inspection :	May 7, 8, 9, 10, 11, 14, 15, 16, 17, 18, 25, 28, Jun 11, 12, 18, 2012
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH CENTRE OF SUDBURY 1140 South Bay Road, SUDBURY, ON, P3E-0B6
LTC Home / Foyer de SLD :	ST. JOSEPH'S VILLA, SUDBURY 1250 South Bay Road, SUDBURY, ON, P3E-6L9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JO-ANNE PALKOVITS

To ST. JOSEPH'S HEALTH CENTRE OF SUDBURY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the care set out in the plan of care is provided to each resident as specified in the plan.

The plan shall be submitted in writing to Long Term Care Homes Inspector Monique Berger, Ministry of Health and Long Term Care Performance and Compliance Branch , 159 Cedar Street, Sudbury, Ontario, P3E 6A5 by June 25, 2012

Grounds / Motifs :

1. The care plan for a resident directs staff to ensure a resident is wearing heel protection boots to the feet. . Inspector observed the resident sitting at the dining room table with feet resting on a pillow, no heel protection boots applied.
The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007,S.O.2007, c. 8, s. 6 (7).] (196)
2. Inspector observed a resident lying in bed not positioned as per the family's request identified in the plan of care.
The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007, S.O.2007,c. 8, s. 6 (7).] (196)
3. Inspector reviewed the health record for a resident requiring a dietary supplement. Inspector noted that the resident had a dietician order for a supplement to be given several times per day. The MAR (Medication Administration Record) information for the resident confirms the order that the resident was to receive a dietary supplement several times per day. Inspector audited the MAR record for this resident and noted there were numerous staff signatures missing accounting for the administration of the treatment. For the period of the Inspector's audit, 42% of the accountability signatures were found to be missing. Inspector noted the MAR record has codes that provide for identification as to why the treatment/medication may not have been given. I.e. 1 = drug refused. No codes are provided in lieu of missing signatures of accountability.
Inspector spoke to staff who confirmed that if there is no accountability signature, then it means that the supplement was not given.
The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (7)] (106) (151)
4. Inspector overheard a resident to ask staff to provide assistance to the washroom. The staff was overheard telling the resident "you will be okay" and then observed the staff to leave the resident and walk down the hall, not having provided the assistance requested. Inspector interviewed the resident . The resident informed the Inspector that the request was made because the resident felt weak and that the staff person had not provided the assistance requested. Inspector interviewed the staff person assigned to care for the resident and was told that staff provide total continence care in the morning but, for the rest of the day, would only assist the resident if the need was for a bowel movement. Inspector reviewed the plan of care for the resident. Under the focus of toileting, the plan of care identified that the resident required one person assist for all toileting needs. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (7)] (106)
5. Inspector observed a resident sitting in a specialized wheelchair in the resident's bedroom. Resident was leaning to the side with left foot hanging off the end of the foot rest, no support for the left arm,and with face soiled with food debris. Inspector reviewed the resident's health care record and noted that the MDS quarterly assessment identified that the resident requires full assist with all ADL's (activities of daily living) with one or two staff . The plan of care identified that staff are to provide total care for all hygiene needs. On the day of the Inspector's observation, the resident was not positioned properly while up in the wheelchair and food debris had not been removed from the resident's face. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007, S.O.2007,c. 8, s. 6 (7).] (196)
6. Inspector reviewed a resident's health care record and noted that the plan of care stated the resident was to receive physical assistance for hygiene/grooming needs and encouragement/cues to complete some tasks independently;i.e.washing own hands and face. In an interview, the staff person assigned to care for the resident told the Inspector that staff do not provide any hygiene assistance to the resident.
The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (7)] (106) (106)
7. Inspector reviewed the plan of care for a resident . Inspector noted under the "dressing" section it identified the resident required extensive to total assistance for dressing. The plan of care further identified that staff are to ensure clothing and footwear are clean and appropriate. Inspector observed the resident on several occasions to not be wearing the proper footwear. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007, S.O. 2007, c.8, s.6(7)] (188)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 16, 2012

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan ensuring that the written plan of care for each a resident sets out clear directions to staff and others who provide direct care to the resident.

The plan shall be submitted in writing to Long Term Care Homes Inspector Monique Berger, Ministry of Health and Long Term Care Performance and Compliance Branch, 1259 Cedar Street, Sudbury, Ontario, P3E 6A5 by June 25, 2012.

Grounds / Motifs :

1. Inspector reviewed the written plan of care for a resident . The plan of care had 2 different instructions to staff in regards to the same care intervention related to the positioning of the resident when in bed. The written plan of care contains inconsistent directions to staff and others who provide direct care to the resident in regards to the positioning of the resident . The licensee failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. [LTCHA 2007, S.O.2007, c. 8, s. 6 (1)(c)] (196)
2. Inspector reviewed the health care record, including plan of care, for a resident . Inspector noted an intervention related to bladder incontinence that identified the resident was to wear a brief at all times. Inspector noted an intervention related to toileting that identified the resident is not to wear a brief during the day. This conflicting direction does not provide clear direction to staff related to the resident's use of incontinent products during the day. The licensee failed to ensure that the plan of care provides clear direction to staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c.8, s.6(1)(c)] (188)
3. Inspector spoke with staff who identified that a resident required staff assistance for toileting. Staff told the Inspector the resident was being toileted every morning, before and after meals and at any other time when necessary. Inspector then reviewed the plan of care for this resident and noted it confirmed the resident required staff assistance for toileting but failed to provide any direction as to the frequency to toilet the resident. The licensee failed to ensure the plan of care provides clear direction to staff and those providing direct care to the resident. [LTCHA 2007, S.O. 2007, c.8, s.6(1)(c)] (188)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 16, 2012

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan that will ensure that each resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, a goal in the plan is met, the resident's care needs change or care set out in the plan is no longer necessary; or care set out in the plan has not been effective.

The plan shall be submitted to Long Term Care Homes Inspector Monique Berger, Ministry of Health and Long Term Care Performance and Compliance Branch, 159 Cedar Street, Sudbury, Ontario, P3E 6A5 by June 25, 2012.

Grounds / Motifs :

1. Two staff reported that a resident no longer uses partial dentures. The most recent "Oral Screening Assessment" for the resident indicates resident seldom wears dentures. The plan of care for the resident states that the resident has some own teeth as well as upper/lower partial plates. Staff are to complete oral care for partials and provide constant supervision and cueing while resident brushes own teeth."
As the resident no longer wears dentures, the plan of care regarding oral care is not current. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (10 (b)] (106)
2. Inspector reviewed the written plan of care for a resident. In this care plan, the focus of fall prevention included the interventions as follows: "apply lap table restraint when up in chair for safety. Call bell pinned to gown when in bed. Undo, reapply restraint q2h. Reposition resident and document in restraint record q2h." Staff interview related to the use of restraints for this resident identified that the use of the restraint and the call bell pinned to gown when in bed were no longer used as the resident was no longer considered at risk for falls. "
The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (10 (b)] (196)
3. Inspector reviewed the care plan for resident a resident. The focus of "risk for falls" included the interventions of "call bell pinned to gown when in bed, ensure bed alarm is attached to resident when in bed for safety, resident is at high risk for falls, check hourly for comfort and safety while belt is in use, put 2 (two) upper side rails up when in bed for safety". Interview of the staff assigned to the resident identified that the resident no longer uses a bed alarm or belt for safety and that all four side rails are to be up when in the resident was in bed.
The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (10 (b)] (196)
4. Inspector reviewed the care plan for a resident and noted that the resident is to wear dentures. Interview with the resident family showed that dentures no longer fit and have not been worn for a long time. The licensee has not revised the care plan to include this new information .
The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary; [LTCHA 2007, S.O.2007,c. 8, s. 6 (10)(b)]. (196)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 16, 2012

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and that in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The plan shall be submitted to Long Term Care Homes Inspector Monique Berger, Ministry of Health and Long Term Care Performance and Compliance Branch, 159 Cedar Street, Sudbury, Ontario, P3E 6A5 by June 25, 2012.

Grounds / Motifs :

1. Inspector reviewed the plan of care for a resident . In the section, "HYGIENE/GROOMING", the plan of care states: "Provide physical assist ie. washing back, underarms, abdominal folds and peri areas. ++ encouragement needed for resident to wash own face and hands". Inspector , reviewed the most recent "accepted", RAI MDS assessment for the resident. In section "G", in regards to personal hygiene, the assessment identifies that the resident is "independent, setup help only". The plan of care does not align with the RAI/MDS assessment. The resident's plan of care directs staff to give extensive physical assistance for hygiene and grooming care, while the RAI/MDS assessment identifies the resident as needing minimal assistance: "set up only". The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (4) (a)] (106) (106)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 16, 2012

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board

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

and the

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 18th day of June, 2012

Signature of Inspector / Signature de l'inspecteur : Monique G. Berger

Name of Inspector / Nom de l'inspecteur : MONIQUE BERGER

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

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

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 7, 8, 9, 10, 11, 14, 15, 16, 17, 18, 25, 28, Jun 11, 12, 18, 2012	2012_138151_0013	Resident Quality Inspection

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH CENTRE OF SUDBURY
1140 South Bay Road, SUDBURY, ON, P3E-0B6

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

ST. JOSEPH'S VILLA, SUDBURY
1250 South Bay Road, SUDBURY, ON, P3E-6L9

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

MONIQUE BERGER (151), LAUREN TENHUNEN (196), MARGOT BURNS-PROUTY (106), MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care, Social Worker, Manager of Environmental Services, Recreation and Activation Coordinator, Dietitian, Food Service Supervisor,Therapy Aides, Registered Nursing Staff,Personal Support Workers (PSW), residents, family and visitors.

During the course of the inspection, the inspector(s)
- toured the home daily,
- directly observed care and service delivery to residents
- reviewed resident health care records
- reviewed related policies and procedures
- reviewed the following programs: continence care and bowel management, falls prevention, skin and wound , responsive behaviour management, infection control program, pain management
- observed resident dining service,
- reviewed staffing schedules

IN TANDEM TO RESIDENT QUALITY INSPECTION (RQI) ACTIVITIES: Inspectors reviewed issues arising from the following Critical Incident Reports:
- Log #: S-001978-11 related to Critical Incident 2913-000016-11,
- Log #: S-001838-11 related to Critical Incident 2913-000015-11,
- Log #: S-000338-12 related to Critical Incident 2913-000006-12,
- Log #: S-000070-12 related to Critical Incident 2913-000001-12,
- Log.#: S-002168-11 related to Critical Incident 2913-000019-11.

IN TANDEM TO RESIDENT QUALITY INSPECTION (RQI) ACTIVITIES: inspectors reviewed issues arising from the following complaints:Log.#: S-000465-12, Log.#: S-000012-12, Log.S-000013-12, Log.# S-002025-11/ S-000012 -12, Log.# S-001906-11,Log.#:S-001750-11, Log.#:S-000300-12.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Reporting and Complaints

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Training and Orientation

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

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

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

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

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

Findings/Faits saillants :

1. Inspector reviewed the plan of care for a resident. Inspector noted under the dressing section it identified the resident required extensive to total assistance for dressing. The plan of care further identified that staff are to ensure clothing and footwear is clean and appropriate. Inspector observed the resident on 3 separate occasions to not be wearing appropriate footwear. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007, S.O. 2007, c.8, s.6(7)]

2. Inspector reviewed a resident's health care record and noted that the resident's plan of care stated: "HYGIENE/GROOMING: provide physical assistance: ie. washing back, underarms, abdominal folds and peri areas. ++ encouragement needed for resident to wash face and hands." In an interview, the staff member assigned to care for the resident told the Inspector that staff do not provide any hygiene assistance to the resident and that the resident will not allow staff to provide any personal care.
The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (7)]

3. Inspector reviewed the plan of care for a resident. In the section, "HYGIENE/GROOMING", the plan of care states: "Provide physical assist ie. washing back, underarms, abdominal folds and peri areas. ++ encouragement needed for resident to wash own face and hands". Inspector, reviewed the most recent "accepted", RAI MDS assessment for this resident. In section "G", in regards to personal hygiene, the assessment identifies that the resident is "independent, setup help only". The plan of care does not align with theRAI/MDS assessment. The resident's plan of care directs staff to give extensive physical assistance for hygiene and grooming care, while the RAI/MDS assessment identifies the resident as needing minimal assistance: "set up only". The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (4) (a)]

4. Inspector observed a resident sitting in a specialized wheelchair in the resident's room, leaning to the side with left foot hanging off the end of the foot rest, no support for the left arm, and, with face soiled with food debris. Inspector reviewed the resident's health care record and noted that the MDS quarterly assessment identified that the resident requires full assist with all ADL's (activities of daily living) with one or two staff. The plan of care identifies that staff are to "provide total care to provide mouth care, comb hair, shave, wash/dry face/hands and perineum". On the day of the Inspector's observation, the resident was not positioned properly while up in the wheelchair and food debris had not been removed from the face. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007, S.O.2007,c. 8, s. 6 (7).]

5. Inspector reviewed the care plan for a resident and noted family wants him to wear dentures". In an interview with family, the Inspector was advised the resident's dentures no longer fit and have not been worn for some while. The licensee has not revised the care plan to include this new information .
The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary; [LTCHA 2007, S.O.2007,c. 8, s. 6 (10)(b)].

6.Inspector overheard a resident to ask staff to provide assistance to the washroom. The staff was overheard telling the resident "you will be okay". Inspector observed the staff to then leave the resident and walk down the hall, not having provided the assistance requested. Inspector interviewed the resident who told the Inspector assistance was requested because of a feeling of weakness, however she was refused this assistance. On this same day, Inspector asked the staff who was assigned to care for resident what continence care was to be provided for the resident. The staff reported that staff provide total continence care in the morning but, for the rest of the day, would only assist the resident if the resident had a bowel movement. The plan of care for the resident was reviewed by the Inspector. Under the focus "TOILETING - the plan of care identified the resident needed one staff assistance for all toileting needs. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (7)]

7. Inspector reviewed the care plan for a resident. The focus of "risk for falls" included the interventions of "call bell pinned to gown when in bed, ensure bed alarm is attached to resident when in bed for safety, resident is at high risk for

falls, check hourly for comfort and safety while belt is in use, put 2 (two) upper side rails up when in bed for safety". Interview of staff assigned to the resident identified that the resident no longer uses a bed alarm or belt for safety and that all four side rails are to be up when in the resident was in bed.
The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (10 (b)]

8. Inspector reviewed the written plan of care for a resident. In this care plan, the focus of fall prevention included the interventions as follows: "apply lap table restraint when up in chair for safety. Call bell pinned to gown when in bed. Undo, reapply restraint q2h. Reposition resident and document in restraint record q2h." Staff interview related to the use of restraints for this resident identified that the use of the restraint and the call bell pinned to gown when in bed were no longer used as the resident was no longer considered at risk for falls. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (10) (b)]

9. Inspector reviewed the health record for a resident requiring a dietary supplement. Inspector noted that the resident had a dietician order for a supplement to be given several times per day. The MAR (Medication Administration Record) information for the resident confirms the order that the resident was to receive a dietary supplement several times per day. Inspector audited the MAR record for this resident and noted there were numerous staff signatures missing accounting for the administration of the treatment. For the period of the Inspector's audit, 42% of the accountability signatures were found to be missing. Inspector noted the MAR record has codes that provide for identification as to why the treatment/medication may not have been given. I.e. 1 = drug refused. No codes are provided in lieu of missing signatures of accountability.
Inspector spoke to staff who confirmed that if there is no accountability signature, then it means that the supplement was not given.
The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (7)[(106)

10. Inspector spoke with staff who identified that the resident required staff assistance for toileting. Staff told the Inspector the resident was being toileted every morning, before and after meals and at any other time when necessary. Inspector then reviewed the plan of care for this resident and noted it confirmed the resident required staff assistance for toileting but failed to provide any direction as to the frequency to toilet the resident. The licensee failed to ensure the plan of care provides clear direction to staff and those providing direct care to the resident. [LTCHA 2007, S.O. 2007, c.8, s.6 (1)(c)[

11. Inspector observed a resident lying in bed not positioned as per the family's request identified in the plan of care. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007, S.O.2007,c. 8, s. 6 (7).]

12. Inspector reviewed the health care record, including plan of care, for a resident . Inspector noted an intervention related to bladder incontinence that identified the resident was to wear a brief at all times. Inspector noted an intervention related to toileting that identified the resident is not to wear a brief during the day. This conflicting direction does not provide clear direction to staff related to the resident's use of incontinent products during the day. The licensee failed to ensure that the plan of care provides clear direction to staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c.8, s.6(1)(c)]

13. Inspector reviewed the written plan of care for a resident. The plan of care had 2 different instructions to staff in regards to the same care intervention related to the positioning of the resident when in bed. The written plan of care contains inconsistent directions to staff and others who provide direct care to the resident in regards to the positioning of the resident. The licensee failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. [LTCHA 2007, S.O.2007, c. 8, s. 6 (1)(c)]

14.Two staff reported that a resident no longer uses partial dentures. The most recent "Oral Screening Assessment" for

the resident indicates resident seldom wears dentures. The plan of care for the resident states that the resident has some own teeth as well as upper/lower partial plates. Staff are to complete oral care for partials and provide constant supervision and cueing while resident brushes own teeth."
As the resident no longer wears dentures, the plan of care regarding oral care is not current. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (10 (b)]

15. The care plan for a resident directs staff to ensure a resident is wearing heel protection boots to the feet. Inspector observed the resident sitting at the dining room table with feet resting on a pillow, no heel protection boots applied.
The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007,S.O.2007, c. 8, s. 6 (7).[

Additional Required Actions:

CO # - 001, 002, 003, 004 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. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1.Inspector inspected the medication cart. Inspector noted the controlled medication Ativan was stored in the main area of the medication cart and not in the separate locked cabinet in the cart. The licensee failed to ensure that 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) (b)] (106)

2. Inspector noted that on four days of the inspection, a resident had a medication at the bedside and was self-administering this medication. No registered staff were observed to be in the room at any time during the inspector's observations. Inspector reviewed the resident's health care record and could find no physician order that the resident could administer the medication independently. Inspector did note that on the MAR record for March 2012, there was a hand-written note stating: "not to be left at the bedside, we do not have physician order or approval to do so". Inspector interviewed a staff who confirmed that this was their note written and who confirmed that currently there was no order or authority for the resident to have the medication at the bedside.
The licensee did not ensure that drugs are stored in an area or a medication cart,
i. that is used exclusively for drugs and drug-related supplies,
[O.Reg.79/10, s. 129 (1) (a) i]

3. Inspector observed the medication cart on Sunnyside Unit. Inspector noted that pouches of medications containing tablets of Ativan .5mg were in the bottom drawer of the cart. Also, the medication cart held medication cards containing Ativan for two residents. The medication Ativan is a controlled substance and it was found not to be stored in a separate locked area within the locked medication cart.
The licensee failed to ensure that, (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)(b)]

4. The Inspector reviewed the medication storage room (med room) on Gardenway Unit. Inspector noted the storage cupboard contained a bottle of calcium citrate with an expiration date of August 2009. Inspector reported it to the registered staff who confirmed that the medication was expired. The licensee failed to ensure that drugs are stored in an area that complies with the manufacturer's instructions. [O.Reg. 79/10, s.129(1)(a)]

5. On Hillcrest Unit, Inspector noted that the controlled medication Ativan is not being stored in a separate locked area in the medication cart .
The licensee does not ensure that 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)(b)]

6. During medication administration observation on Hillcrest Unit, Inspector noted the following in regards to medications exceeding their expiration dates: Triancinal H20 Nose Spray with an expiration date of July 2011(medication cart), Biscodyl 5 mg. expired in March 2011: 3 boxes (medication room), Tubersol 5 units/dose with expiration date of April 26, 2012 (fridge in medication room), 5 vials of Lorazepam Injectable with expiration dates of November 2010 (medication room).
The licensee failed to ensure that drugs are stored in an area that complies with the manufacturer's instructions. [O.Reg. 79/10, s.129(1)(a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that drugs are stored safely and in accordance with the requirements stipulated in O.Reg.79/10, s.129, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1.Inspector reviewed the most recent RAI MDS "accepted" assessment for a resident. The assessment indicates that the resident has moderate pain daily. Staff reported to Inspector that the resident requests PRN analgesic daily. For this resident ,the focus, goals or interventions sections of the plan of care contain no references in regards to the resident's pain management needs. The licensee failed to ensure that the plan of care is based on an interdisciplinary assessment with respect to the resident's health conditions including allergies, pain, risk of falls and other special needs. [O. Reg. 79/10, s. 26 (3) 10]

2. Inspector reviewed a resident's health care record and plan of care. Inspector noted that the resident's MDS assessment completed identified the resident as incontinent of both bowel and bladder. Inspector review of the resident's plan of care identified the resident as incontinent of bowel but failed to identify the resident's bladder incontinence. The licensee failed to ensure that the plan of care is based on an interdisciplinary assessment of the residents continence, including bladder and bowel elimination. [O.Reg. 79/10, s.26(3)(8)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident's plan of care meets the requirements stipulated in O.Reg.79/10, s.26 (3)8,10, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following subsections:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;
(e) continence care products are not used as an alternative to providing assistance to a person to toilet;
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. inspector observed a resident sitting in a wheelchair in the TV lounge from 1325 to 1535hrs. During this time, Inspector did not observe the resident to be offered continence care assistance. Inspector reviewed the resident's plan of care and noted that the resident was dependent on staff for all activities of daily living and continence care. Inspector observed that the resident had a strong smell of urine.
The licensee failed to ensure residents who require continence care products have sufficient changes to remain clean, dry and comfortable. [O.Reg.79/10,s.51(2)(g)]

2.Inspector observed a resident to ask a staff to provide assistance to the washroom. Staff told the resident: "you will be okay". Staff then proceeded down the hallway without providing the assistance requested. The most recent RAI MDS assessment identified that the resident required extensive physical assistance of one person for toileting. The licensee failed to ensure that each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence. [O. Reg. 79/10, s. 51 (2) (c)]

3. Inspector reviewed the plan of care for a resident. Inspector noted the resident required staff assistance for toileting. Inspector noted one intervention which identified staff are to ask the resident to go to the toilet every 30 minutes and a second intervention which identified the resident was to be toileted before and after meals. Inspector observed the resident from 09:06h until 11:53h. During this time span, the resident was in the dining lounge and the Inspector at the nursing station with direct view of the resident. Inspector noted the resident was at no time approached in regards to toileting needs. The licensee failed to ensure that a resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence. [O.Reg. 79/10, s.51(2)(c)[

4. Inspector reviewed the health care record of a resident. Inspector noted the resident's plan of care identified the resident as incontinent of both bladder and bowel. Inspector reviewed the assessments for the resident and was unable to locate an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions which was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. The inspector spoke with the staff who confirmed that a new continence assessment tool has been selected for use in the home; however it has not yet been implemented. The licensee failed to ensure that a resident who is incontinent receives an assessment using a clinically appropriate assessment instrument. [O.Reg. 79/10, s.51(2)(a)]

5. Inspector reviewed the health care record of another resident. Inspector noted the resident's plan of care identifies the resident as incontinent of both bladder and bowel. Inspector reviewed the completed assessments for the resident and was unable to locate an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions which was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. The inspector spoke with staff who confirmed that a new continence assessment tool has been selected for use in the home; however it has not yet been implemented. The licensee failed to ensure that a resident who is incontinent receives an assessment using a clinically appropriate assessment instrument. [O.Reg. 79/10, s.51(2)(a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring the home develops and implements a continence care program that meets all the requirements of the regulations: specifically O.Reg.79/10, s.51 (2)(a)(c)(g), to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following subsections:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. Inspector interviewed four direct care staff members who confirmed and that they had not received training in the protections afforded by section 26, whistle-blowing protection. Inspector interviewed a further staff who confirmed that only new hires have received training in whistle-blowing protection.
The licensee failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 5. The protections afforded by section 26. [LTCHA 2007,S.O.2007,c.8,s.76.(2)5.]

2. Inspector interviewed four direct care staff who confirmed they did not have a clear understanding of the duty under section 24 to make mandatory reports. Inspector interviewed a further staff who confirmed that, at the time of the inspection, only new hires had received training in mandatory reporting.
The licensee failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: **4.** The duty under section 24 to make mandatory reports. [LTCHA 2007,S.O.2007,s.76(2)4.[

3. Inspector noted that the home does make use of agency staff as staffing need arises. Inspector reviewed the orientation and education records for the agency staff who have attended the home and who have provided direct resident care. Inspector noted that of the 10 different agency staff who have worked shifts and provided resident care at the home, only 2 have attended on-site orientation. Inspector spoke with staff who identified that an agency staff orientation package has been provided to the agencies themselves. Staff confirmed that the home has not verified that all the agency staff persons, who have worked shifts in the home, have actually received and read the packages provided previous to allowing them to attend to residents in the home. Staff identified that the home does not have a record of orientation or training for the other 8 agency staff members that have worked shifts in the home. The licensee failed to ensure that all staff receives training in the required areas prior to performing their responsibilities. [LTCHA 2007, S.O. 2007, c.8, s.76(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 that ensures that all staff at the home receive training as required by the regulations, specifically LTCA,2007 S.O.2007,c.8, s.76 (2), to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following subsections:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items;
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and
(d) industrial washers and dryers are used for the washing and drying of all laundry. O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. Inspector spoke with various personal support workers from each resident home area. It was reported to the Inspector that there was not a sufficient supply of linen available, specifically a lack of peri-cloths, facecloths and hand towels. Staff related that sometimes they have to use large bath towels when providing care (other than baths) because no other linen is available. Inspector toured the clean linen room on two of the units. The linen carts on these units contained no stock of peri-cloths, facecloths or hand towels. The licensee failed to ensure there is a sufficient supply of clean linens, face cloths and bath towels always available in the home for use by the residents. [O.Reg. 79/10, s. 89(1)(b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a sufficient supply of clean linen, face cloths and bath towels available in the home for use by the residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1.Inspector reviewed the licensee's written policy titled "Zero tolerance of Abuse and Neglect" with a revision date February 7, 2012. The policy did not identify the training and retraining requirements for all staff including, training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations.
The licensee failed to ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, (e) identifies the training and retraining requirements for all staff, including, (i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and (ii) situations that may lead to abuse and neglect and how to avoid such situations. [O.Reg.79/10,s.96.(e).]

2. Inspector reviewed the licensee's policy titled "Zero tolerance of Abuse and Neglect" with revision date of February 7, 2012. The policy did not contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected.
The licensee failed to ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, (a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected; [O.Reg.79/10,s.96.(a)].

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the licensee's written policy to promote zero tolerance of abuse and neglect of residents contains all the requirements listed in O.Reg.79/10, s. 96 (a)(e), to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. Inspector reviewed the documentation relating to restraint application for a resident. Inspector noted that under a section titled "resident response", staff documented 29 different entries that the resident was agitated. Inspector found no further documentation within the restraint record nor within the resident's progress notes in regards to the resident's agitation. Inspector spoke with 2 staff who confirmed that any further assessment of a resident's condition, including assessment if the resident was agitated, should be included in the resident's progress notes. The licensee failed to ensure the resident's condition is reassessed and the effectiveness of the restraining evaluated by a member of the registered nursing staff based on the resident's condition or circumstances. [O.Reg. 79/10, s.110(2)(6)]

2. Inspector reviewed the documentation related to restraint removal for a resident. When reviewing the documentation, Inspector noted that removal of the device was only documented on five occasions over the 10 day audit period. Inspector reviewed the resident's normal sleep-rest routine and found that the device is applied and removed twice daily and this would indicate that there should have been a total of 20 restraint application and removal documentations. Inspector spoke with staff who confirmed the restraint had been applied and removed each day. In addition, staff identified that within their documentation system(point of care)and in regards to restraints, staff are only able to select one action. For example: if the resident in a restraint had an incontinent product change, it would be this that would be documented. There is no ability for the system to accommodate a second action: i.e. documenting the removal of the device. The licensee failed to ensure that the documentation includes removal of the physical device, including time of removal and post removal care. [O.Reg. 79/10, s.110(7)(8)]

3. Inspector spoke with staff who identified that reassessment of the residents' restraint by registered staff is to be done every eight hours and that this is documented on the individual resident's medication administration record (MAR) sheet. Inspector reviewed the March, April and May MAR sheets for a resident. Inspector noted that the March MAR sheet was missing 22 accountability signatures for the evening shift and contained no signatures for the night shift for restraint reassessment by registered nursing staff. Inspector noted the April MAR sheet was missing 28 evening accountability signatures and contained no signatures for the night shift for restraint reassessment by registered nursing staff. Inspector reviewed the May MAR sheet for the first 10 days of May. Inspector noted that one accountability signature was missing for the day shift, seven accountability signatures were missing for the evening shift and the report contained no signatures for the night shift for restraint reassessment by registered nursing staff. The licensee failed to ensure that the documentation includes all assessments, reassessments and monitoring of the resident. [O.Reg. 79/10, s.110(7)(6)]

4. Inspector reviewed the documentation related to restraint application for a resident. When reviewing documentation, the Inspector noted that application of the device was only documented on two occasions over the 10 day period audited. Inspector confirmed that during the resident's normal sleep-rest routine the device includes the applied and removal of the restraint twice daily. This indicates that there should be a total of 20 application documentation notes. Inspector spoke with staff who confirmed the restraint had been applied and removed each day. In addition, staff identified that within their documentation system(point of care)and in regards to restraints, staff are only able to select one action. For example: if the resident in a restraint had an incontinent product change, it would be this that would be documented. There is no ability for the system to accommodate a second action: i.e. documenting the removal of the device. The licensee failed to ensure that the documentation includes removal of the physical device, including time of removal and post removal care. [O.Reg. 79/10, s.110(7)(8)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures all the requirements relating to restraining by a physical device are met, specifically in reference to O.Reg.79/10, S.110(2) and S.110 (7)6,7,8, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following subsections:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. Inspector reviewed the health care records and medication incident report relating to a resident. Inspector did not find documentation of the immediate actions taken to assess and maintain the resident's health. In addition, the documented record does not identify that the resident's SDM, the Medical Director, the attending physician or the pharmacy service provider were notified of the medication incident.
The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction is, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [O. Reg. 79/10, s. 135 (1)(a)(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 that ensures every medication incident involving a resident and every adverse drug reaction is: documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. Inspector reviewed the written plan of care for a resident. The focus of hygiene and grooming identified that the staff are to "provide total care to provide mouth care, comb hair, shave, wash/dry face/hands and perineum". On Inspector observed the resident sitting in a wheelchair, unshaven on one occasion. On a second occasion, Inspector observed the resident to be partially unshaven with food debris present on the right side of the mouth.
The licensee failed to ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. [O. Reg. 79/10, s. 32]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. Inspector received information alleging that a resident did not receive two baths a week. The Inspector's source identified that this is especially true for 2 recent months and that during these months the residents missed "many baths". Inspector reviewed the bath record for the two months in question. For the first of these months, the resident received only 5 of the required 8 baths. Inspector reviewed the bath record for the second month and noted the resident received only 5 of the required 8 baths for that month. Inspector reviewed the resident's progress notes and could not find any further documentation to suggest why the resident did not receive all scheduled baths. The licensee failed to ensure that residents are bathed, at a minimum, twice a week by a method of his or her choice. [O.Reg. 79/10, s.33(1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following subsections:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. In an interview with Inspector, staff confirmed that the home does not have a pain management program to identify and manage pain in residents. The licensee failed to ensure that an interdisciplinary pain management program was developed and implemented in the home. [O.Reg. 79/10, s.48(4)]

2. In an interview with Inspector, staff confirmed the home does not have a continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. The licensee failed to ensure that an interdisciplinary continence care management program was developed and implemented in the home. [O.Reg. 79/10, s.48(3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures the home develops and implements a pain management program and a continence care program that meet the requirements of O.Reg.79/10, s.48, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. On May 10, 2012 from 1325 h to 1535 h, Inspector observed resident from the hours of 1325 h to 1535 h. Resident was sitting in a wheelchair in the TV lounge. Inspector noted that during this time interval, the resident's position was not changed. The resident's care plan was reviewed and it identified that resident was to be turned and repositioned every two hours.
The licensee failed to ensure that any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. [O.Reg.79/10,s.50(2)(d).]

2. Between the hours of0845 h to 1110 hrs, Inspector observed a resident to be in the same position in her bed. the resident was identified as requiring total staff assistance for mobility. The plan of care directs that the resident is to be repositioned every 2 to 3 hours to maintain good skin integrity because of the resident's inability to move without assistance.
The licensee failed to ensure that, (d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. [O.Reg.79/10,s.50.(2)(d)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.

Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,

(a) use of physical devices;

(b) duties and responsibilities of staff, including,

(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,

(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device;

(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others;

(d) types of physical devices permitted to be used;

(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented;

(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and

(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. Inspector reviewed the home's minimizing of restraining policy. Inspector noted the policy, titled "least restraint policy", fails to identify staff responsibilities including ensuring that all appropriate staff are aware at all times of when a resident is being restrained by a physical device.
The licensee failed to ensure the written policy addresses the duties and responsibilities of the staff including ensuring that all appropriate staff are aware at all times of when a resident is being restrained by a physical device [O.Reg. 79/10, s.109(b)(ii)]

2. Inspector reviewed the home's minimizing of restraining policy. Inspector noted the policy, titled "least restraint policy" fails to identify staff responsibilities including who has the authority to apply or release a physical device. The licensee failed to ensure their written policy includes staff responsibilities including who has the authority to apply or release a physical device. [O.Reg. 79/10, s.109(b)(i)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following subsections:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces;
(c) removal and safe disposal of dry and wet garbage; and
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. On Tuesday May 8 and Thursday May 10, 2012, Inspector observed the blue Arjo lift in the hallway of the Hillcrest unit to be heavily soiled with accumulated debris on it's base. The same type and amount of debris was observed on the lift base on both these days. In an interview staff identified that the cleaning of the resident lift equipment is an assignment for PSW staff. Inspector obtained a copy of the staff work routines for Hillcrest Unit. In regards to the cleaning of resident lifts, the schedule directed night shift PSW staff to clean the lifts on Tuesdays, Thursdays and Saturdays.
The Licensee failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee failed to ensure that procedures are developed and implemented for, (b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices: (i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs, [O. Reg. 79/10, s. 87 (2)(b)(i)].

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. Inspector reviewed the home's policy relating to minimizing of restraining of residents titled "least restraint policy". Inspector noted that under a section titled "ongoing use of restraints", it identifies "a member of the registered nursing staff i.e. RN or RPN will reassess the resident's condition and the effectiveness of restraining at least every 8 hours. This will be documented." On May 11, 2012, Inspector reviewed the March, April and May MAR sheets for a resident to review documentation of the every 8 hour reassessments. Inspector noted that the MAR sheets for all the identified months did not contain reassessment accountability signatures on any of the night shifts. As per the home's policy, the every 8 hours reassessment by registered nursing staff was not documented as done. The licensee failed to ensure that their policy was complied with. [LTCHA, 2007, S.O. 2007, c.8, s.29(1)(b)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. Repeated observations made by 2 (two)Inspectors on 3 subsequent days identified the same and continued housekeeping issues on all the days of observations:
- dead insects on the table in the TV room in Lakeview Unit,
- food debris on the floor in the TV room in Lakeview Unit and,
- plant debris on the floor at the end of the hallway of Lakeview Unit.
The licensee failed to ensure that, (a) the home, furnishings and equipment are kept clean and sanitary; [LTCHA 2007, S.O.2007, c. 8, s.15(2)(a)].

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. Staff related to the Inspector that the resident had issues of responsive behaviours. Interview with a second staff confirmed this same information in regards to the resident. The plan of care for this resident does not contain any techniques or intervention to prevent, minimize or respond to these responsive behaviours. The licensee failed to ensure that written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours are developed to meet the needs of residents with responsive behaviours. [O. Reg. 79/10, s. 53 (1) 2]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following subsections:

s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;
(c) standardized recipes and production sheets for all menus;
(d) preparation of all menu items according to the planned menu;
(e) menu substitutions that are comparable to the planned menu;
(f) communication to residents and staff of any menu substitutions; and
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. Inspector observed the supper meal service in the Gardenway Unit. Inspector noted the posted menu identified Salisbury Steak, risotto and wax beans as the main choice. Inspector noted staff offering Sheppard's pie to the residents in lieu of Salisbury Steak. Shepherds Pie was not on the daily posted menu board, nor in the "Week at a Glance" menu posting for that day. There was no evidence found that indicated that the residents were advised of the substitutions prior to the meal. Inspector spoke with staff about the menu discrepancy. These staff related the menu was substituted because the correct food order was not made.

On Lakeview Unit, Inspector observed that the same issue to occur. The posted daily menu for the supper meal included Salisbury Steak. This day, Shepherd's pie was substituted for the Salisbury Steak, this substitution was not communicated to residents prior to the meal.

The licensee failed to ensure all menu substitutions are communicated to residents and staff. [O.Reg. 79/10, s. 72(2)(f)]

WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following subsections:

s. 86. (1) Every licensee of a long-term care home shall ensure that there is an infection prevention and control program for the home. 2007, c. 8, s. 86. (1).

Findings/Faits saillants :

1. Inspector interviewed staff who confirmed the home does not currently have an infection control program. The licensee failed to ensure that that there is an infection prevention and control program for the home. [LTCHA, 2007, S. O. 2007, c. 8, s. 86 (1)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1.Inspector noted that on four days of the inspection, a resident had a medication at the bedside and was self-administering this medication. No registered staff were observed to be in the room at any time during the inspector's observations. Inspector reviewed the resident's health care record and could find no physician order that the resident could administer the medication independently. Inspector did note that on the MAR record for March 2012, there was a hand-written note stating: "not to be left at the bedside, we do not have physician order or approval to do so". Inspector interviewed a staff who confirmed that this was their note and who confirmed that currently there was no order or authority for the resident to have the medication at the bedside.
The licensee did not ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.[O.Reg.79/10, s.131(5)]

WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following subsections:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. Inspector inspected an issue of family dissatisfaction with the care provided to their resident family member. Review of resident's health care records and review of copies of correspondences related to the issues shows a lapse of 38 days from the time the complaint was received by the licensee to the time that the licensee gave advice to the Director regarding the complaint.
The licensee has not immediately forwarded a written complaint that had been received concerning the care of a resident or the operation of the home to the Director
[LTCA,2007 S.O.2007,c.8, s. 22. (1)]

WN #23: 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 subsections:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) an explanation of the duty under section 24 to make mandatory reports;
(e) the long-term care home's procedure for initiating complaints to the licensee;
(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;
(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;
(h) the name and telephone number of the licensee;
(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;
(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;
(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;
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge;
(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;
(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;
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package;
(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;
(q) an explanation of the protections afforded by section 26; and
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. Inspector reviewed the admission package given to residents and could not locate any reference to whistle blowing and retaliation.
The admission package did not include an explanation of whistle-blowing protections related to retaliation.
[LTCA,2007 S.O.2007,c.8, s. 78. (2) (q)]
2. Inspector reviewed the resident's admission package and observed that the admission package did not include an explanation of the duty to make mandatory reports related to incidents resulting in harm or risk of harm to a resident.
[LTCA,2007 S.O.2007,c.8, s.78 (2)(d)]

WN #24: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. On Gardenway Unit Inspector observed seven residents sitting at dining room tables with clothing protectors applied. Inspector spoke with staff who identified that the clothing protectors were probably just applied for lunch time. Lunch time was identified as being 1200 h., nearly one hour away. Inspector observed another resident on May 8, 2012 on 2 separate occasions: 1002 h and 1415 h. Inspector observed the resident to remain sitting at the table in the dining room with the clothing protector applied. Inspector noted the resident was not eating and did not have any food of fluid at table at the times of the observations.
On May 10, 2012 from 0906 h. to 1153 h., Inspector observed a resident from the nursing desk. For the entire time span of observation, the resident remained sitting at table in the dining room with a` clothing protector applied.
On May 14, 2012 at 0953 h, another Inspector noted that in Gardenway Unit, 3 residents were walking about the unit with their clothing protectors still applied from the breakfast meal.
The licensee failed to ensure that the residents are treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity. [LTCHA, 2007, S.O. 2007, c.8, s.3(1)(1)]

Issued on this 19th day of June, 2012

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

Monique G. Berger (151)