Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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

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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection/ Genre d'inspection
May 08, 2013;	2013_099188_0004 (A1)	S-000002-13	Resident Quality Inspection

Licensee/Titulaire de permis

JARLETTE LTD.
689 YONGE STREET, MIDLAND, ON, L4R-2E1

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

TEMISKAMING LODGE
100 BRUCE STREET, P.O. BOX 1180, HAILEYBURY, ON, P0J-1K0

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

MELISSA CHISHOLM (188) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance date for CO #901 was changed.

Issued on this 8 day of May 2013 (A1)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : MELISSA CHISHOLM (188) - (A1)

Inspection No. / No de l'inspection : 2013_099188_0004 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : S-000002-13 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : May 08, 2013;(A1)

Licensee / Titulaire de permis : JARLETTE LTD.
689 YONGE STREET, MIDLAND, ON, L4R-2E1

LTC Home / Foyer de SLD : TEMISKAMING LODGE
100 BRUCE STREET, P.O. BOX 1180,
HAILEYBURY, ON, P0J-1K0

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : FRANCINE GOSSELIN

To JARLETTE LTD., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure the home is maintained at a minimum temperature of 22 degrees Celsius. This plan shall be submitted by February 8, 2013 and fully implemented by February 22, 2013.

In addition, the licensee shall prepare, submit and implement a plan identifying immediate specific strategies and interventions that will be implemented to ensure residents are kept warm. Further, the plan shall include how the home will obtain, monitor and record the temperatures in the home. The immediate plan shall be submitted by January 24, 2013 at 16:00h.

These plans shall be submitted in writing to Melissa Chisholm, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 603, Sudbury, Ontario, P3E 6A5 or Fax at 705.564.3133

Grounds / Motifs :

1. Inspector 151 and 181 conducted interviews with residents as part of the stage one RQI process. Several residents identified they are cold and the building is not maintained at a reasonable temperature. During observations, inspectors noted windows through the building to be drafty. Some windows were observed to have plastic covering, however this was ineffective in preventing low room temperatures. Residents were also observed to have extra sweaters and blankets applied, however regardless of these strategies, residents continued to complain of the cold. It is noted that outside temperatures were as low as -41C on January 22, 2013. (188)

2. On January 23, 2013 at 08:30h inspector #151 obtained room temperatures. The following was noted.
- Red unit hallway: 19.5C
- Green unit hallway: 19.5C
- Yellow unit hallway: 20.9C
- Boardroom: 15.3C
- Front sitting area near dining room doors: 19.1C
- Large sitting room/TV room: 19.5C
- Dining room: 22.2C
- Resident room #5: 19.2C
- Resident room #12: 18.7C
- Resident room #30: 20.9C
- Resident room #36: 19.5C

The licensee failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. (188)

3. On January 23, 2013 at 13:30h inspector #151 obtained room temperatures. The following was noted.
- Red unit hallway: 20.3C
- Green Unit hallway: 19.8C
- Yellow unit hallway: 23.1C
- Boardroom: 14.6C
- Front sitting area near dining room doors: 21.2C
- Large sitting room/TV room: 20.2C
- Dining room: 22.2C
- Resident room #5: 20.1C
- Resident room #12: 22.1C
- Resident room #16: 20.2C
- Resident room #26: 20.2C
- Resident room #39: 22.0C
- Tub room (while bath in progress): 19.5C

The licensee failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. (188)

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

Feb 25, 2013(A1)

Order # /
Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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 ensure that the plan's of care for resident #733, resident #753 and resident #755 sets out clear directions to staff and others who provide direct care to the resident.

Grounds / Motifs :

1. Inspector received conflicting advice from staff and resident in regards to resident #753 's oral care needs. Inspector reviewed resident #753's plan of care and noted that it provides no direction relating to the resident's oral health or the care required to assist the resident with oral care. The licensee failed to ensure the plan of care provides clear direction to staff and others who provide direct care to the resident. (151)

2. In interviews with the Inspector, staff identified that the resident #753 exhibits responsive behaviours. Inspector observed an incident of responsive behaviour during the inspection. Inspector reviewed the resident's plan of care and found only one focus in reference to the resident's responsive behaviours which discusses the resident's negative feelings, however the interventions speaks to involving the resident in social activities. There are no interventions or direction to staff regarding the majority of the resident's commonly displayed responsive behaviours. The licensee failed to ensure the plan of care sets out clear directions to staff and others who provide direct care to the resident.
(151)

3. In an interview with the inspector, resident #753 identified a preference to nap in the afternoon and wanting to go to bed early in the evening. Inspector reviewed the resident's plan of care and noted that in relation to sleep and rest there is only one intervention which directs staff to administer sleep aids as ordered. The plan of care provides no direction to staff regarding the resident's sleep patterns and preferences. The licensee failed to ensure the plan of care sets out clear directions to staff and others who provide direct care to the resident. (151)

4. In an interview with the inspector, resident #753 identified that the resident has daily pain. Inspector reviewed the resident's health care record including review of the residents medication regime showing that the resident receives analgesic regularly. Inspector reviewed the resident's plan of care and noted it does not identify pain, or provide any direction to staff on pain relief strategies or interventions to address the resident's ongoing pain. The licensee failed to ensure the plan of care sets out clear direction to staff and others who provide direct care to the resident. (151)

5. Inspector reviewed the health care records for resident #733 and noted that the resident suffered significant changes in communication, mobility and transfer ability and continence potential. Inspector reviewed the resident's most recent plan of care and noted it does not identify the changes to the resident's communication, mobility and transfer ability and continence potential. The licensee failed to ensure that plan of care sets out clear direction to staff and others who provide direct care to the resident. (151)

6. Inspector reviewed the health care record for resident #755. Inspector noted progress notes identify the resident regularly refusing treatment, specifically medications. Inspector reviewed the plan of care and noted no direction to staff relating to this refusal of treatment. Further, inspector noted the resident suffered an injury and currently requires treatment for this injury. Inspector noted the plan of care does not include any direction relating to the resident's recent injury, or to direct staff on the change in resident's care needs. The licensee failed to ensure the plan of care sets out clear direction to staff and others who provide direct care to the resident. (188)

7. Inspector reviewed the plan of care for resident #733 and noted it identifies the resident by a picture. However this picture no longer resembles the resident. Further, the plan of care identifies the resident requires a full mechanical lift when weak, however provides no direction to staff on the resident's normal level of transfer and how the resident displays weakness. The licensee failed to ensure the plan of care sets out clear direction to staff and others who provide direct care to the resident. (151)

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

May 10, 2013

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

The licensee shall ensure that resident #747 right to be protected from abuse is fully respected and promoted. Further, the licensee shall ensure that all resident rights are fully respected and promoted for all residents in the home.

Grounds / Motifs :

1. Inspector spoke with resident #474, the resident's family member and staff who all confirmed that on at least one occasion the resident's power wheelchair was taken away for 48 hours as a disciplinary measure following a display of responsive behaviours. The resident was observed to be completely dependent on the power wheelchair for independent mobility. During the time the wheelchair was removed, it was reported the resident was provided a manual wheelchair however the resident is incapable of using the manual wheelchair independently. The resident's ability to be independently mobile was denied as a disciplinary measure. The licensee failed to ensure the resident's right to be protected from abuse was fully respected and promoted. (151)

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

Apr 19, 2013

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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 8 day of May 2013 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : MELISSA CHISHOLM - (A1)

Service Area Office / Bureau régional de services : Sudbury

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection/ Genre d'inspection
May 08, 2013;	2013_099188_0004 (A1)	S-000002-13	Resident Quality Inspection

Licensee/Titulaire de permis

JARLETTE LTD.
689 YONGE STREET, MIDLAND, ON, L4R-2E1

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

TEMISKAMING LODGE
100 BRUCE STREET, P.O. BOX 1180, HAILEYBURY, ON, P0J-1K0

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

MELISSA CHISHOLM (188) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): January 21st - 25th, January 28th - February 1st, 2013

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care, the Registered Nursing Staff (RN/RPN), Personal Support Workers (PSW), the Restorative Care Coordinator, the Administrative Assistant, the Activation and Recreation Lead, Activation Assistants, Dietary Aides, Restorative Care Aides, Resident Council President, Residents and Families.

During the course of the inspection, the inspector(s) conducted tours of resident care areas, observed staff to resident interactions, observed meal service, reviewed various health care records, reviewed various policies and procedures and reviewed staffing schedules.

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

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Food Quality

Hospitalization and Death

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

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. On January 23, 2013 at 13:30h inspector #151 obtained room temperatures. The following was noted.
- Red unit hallway: 20.3C
- Green Unit hallway: 19.8C
- Yellow unit hallway: 23.1C
- Boardroom: 14.6C
- Front sitting area near dining room doors: 21.2C
- Large sitting room/TV room: 20.2C
- Dining room: 22.2C
- Resident room #5: 20.1C
- Resident room #12: 22.1C
- Resident room #16: 20.2C
- Resident room #26: 20.2C
- Resident room #39: 22.0C
- Tub room (while bath in progress): 19.5C

The licensee failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. [s. 21.]

2. On January 23, 2013 at 08:30h inspector #151 obtained room temperatures. The following was noted.
- Red unit hallway: 19.5C
- Green unit hallway: 19.5C
- Yellow unit hallway: 20.9C
- Boardroom: 15.3C
- Front sitting area near dining room doors: 19.1C
- Large sitting room/TV room: 19.5C
- Dining room: 22.2C
- Resident room #5: 19.2C
- Resident room #12: 18.7C
- Resident room #30: 20.9C
- Resident room #36: 19.5C

The licensee failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. [s. 21.]

3. Inspector 151 and 181 conducted interviews with residents as part of the stage one RQI process. Several residents identified they are cold and the building is not maintained at a reasonable temperature. During observations, inspectors noted windows to be drafty. Some windows were observed to have plastic covering,

however this was ineffective in preventing low room temperatures. Residents were also observed to have extra sweaters and blankets applied, however regardless of these strategies, residents continued to complain of the cold. It is noted that outside temperatures were as low as -41C on January 22, 2013. [s. 21.]

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 901

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

s. 6. (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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. Inspector reviewed the plan of care for resident #733 and noted it identifies the resident by a picture. However this picture no longer resembles the resident. Further, the plan of care identifies the resident requires a full mechanical lift when weak, however provides no direction to staff on the resident's normal level of transfer and how the resident displays weakness. The licensee failed to ensure the plan of care sets out clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. Inspector reviewed the health care record for resident #755. Inspector noted progress notes identify the resident regularly refusing treatment, specifically medications. Inspector reviewed the plan of care and noted no direction to staff relating to this refusal of treatment. Further, inspector noted the resident suffered an injury and currently requires treatment for this injury. Inspector noted the plan of care does not include any direction relating to the resident's recent injury, or to direct staff on the change in resident's care needs. The licensee failed to ensure the plan of care sets out clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. Inspector reviewed the health care records for resident #733 and noted that the resident suffered significant changes in communication, mobility and transfer ability and continence potential. Inspector reviewed the resident's most recent plan of care and noted it does not identify the changes to the resident's communication, mobility and transfer ability and continence potential. The licensee failed to ensure that plan of care sets out clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

4. In an interview with the inspector, resident #753 identified that the resident has daily pain. Inspector reviewed the resident's health care record including review of the residents medication regime showing that the resident receives analgesic regularly. Inspector reviewed the resident's plan of care and noted it does not identify pain, or provide any direction to staff on pain relief strategies or interventions to address the resident's ongoing pain. The licensee failed to ensure the plan of care sets out clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

5. In an interview with the inspector, resident #753 identified a preference to nap in the afternoon and wanting to go to bed early in the evening. Inspector reviewed the resident's plan of care and noted that in relation to sleep and rest there is only one intervention which directs staff to administer sleep aids as ordered. The plan of care

provides no direction to staff regarding the resident's sleep patterns and preferences. The licensee failed to ensure the plan of care sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

6. In interviews with the Inspector, staff identified that the resident #753 exhibits responsive behaviours. Inspector observed an incident of responsive behaviour during the inspection. Inspector reviewed the resident's plan of care and found only one focus in reference to the resident's responsive behaviours which discusses the resident's negative feelings, however the interventions speaks to involving the resident in social activities. There are no interventions or direction to staff regarding the majority of the resident's commonly displayed responsive behaviours. The licensee failed to ensure the plan of care sets out clear directions to staff and others who provide direct care to the resident.
[s. 6. (1) (c)]

7. Inspector received conflicting advice from staff and resident in regards to resident #753 's oral care needs. Inspector reviewed resident #753's plan of care and noted that it provides no direction relating to the resident's oral health or the care required to assist the resident with oral care. The licensee failed to ensure the plan of care provides clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

8. Inspector reviewed the resident's plan of care and noted interventions to brush the resident's teeth four times a day, specifically after lunch and staff are required to provide total assistance with oral care. Inspector interviewed staff #101 in regards to the plan of care and was advised that the best the staff could do given their workload was to give the resident oral care in the morning before breakfast and at bedtime. Inspector interviewed staff #102 who confirmed that staff are only brushing the resident's teeth twice a day; in the morning before breakfast and in the evening before bed. The licensee failed to ensure the resident care is provided to the resident as specified in the plan of care. [s. 6. (7)]

9. On January 30, 2013, inspector interviewed two PSWs regarding the level of assistance resident #718 requires with activities of daily living (ADL). Both PSWs reported that the resident was independent with ADLs and does not require any assistance. On January 31, 2013, resident #718 reported to inspector that staff assistance is required for some aspects of grooming, specifically shaving. Inspector observed the resident on January 28 - 31, 2013 and this resident was not shaved on

any of those days, it was also noted on January 28, 2013, resident appeared to have a couple of days facial hair growth. The plan of care for resident #718 was reviewed and it indicates that the resident requires set up and the assistance of one staff person for toileting, hygiene and dressing. The licensee failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. [s. 6. (8)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Inspector spoke with resident #474, the resident's family member and staff who all confirmed that on at least one occasion the resident's power wheelchair was taken away for 48 hours as a disciplinary measure following a display of responsive behaviours. The resident was observed to be completely dependent on the power wheelchair for independent mobility. During the time the wheelchair was removed, it was reported the resident was provided a manual wheelchair however the resident is incapable of using the manual wheelchair independently. The resident's ability to be independently mobile was denied as a disciplinary measure. The licensee failed to ensure the resident's right to be protected from abuse was fully respected and promoted. [s. 3. (1) 2.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. Inspector reviewed the health care record for resident #755. Inspector noted the resident suffered an injury. Inspector noted the resident received PRN analgesic for complaints of pain in the days following this injury. Inspector noted the resident's MDS assessment completed identifies the resident as experiencing pain. The most recent pain assessment was noted to be completed June 23, 2012 and also identifies the resident as experiencing pain regularly. Inspector reviewed the plan of care and was unable to locate any direction relating to pain and pain management. The plan of care does not include any information relating to the residents recent injury, provide direction to staff relating to ongoing assessment of pain, or include the resident's history of pain. The licensee failed to ensure the plan of care is based on an assessment of the resident's health conditions, including pain. [s. 26. (3) 10.]

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 residents' plans of care are based on an assessment of the resident's health conditions, including pain, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The inspector reviewed the home's written policy to minimize the restraining of residents dated July 2011. Inspector noted this policy identifies "it is the effect the device has on the resident that classifies it in the category of restraint, not the name or label given to the device, nor the purpose or intent of the device. If the resident has no voluntary movement (comatose or quadriplegic), or does not have the physical ability or cognitive capacity for rise from any chair, then the resident would not be considered to be restrained". Inspector noted this is not in accordance with the Act, s.30(2) which specifies, "the use of a physical device from which a resident is both physically and cognitively able to release themselves is not a restraining of the resident". The licensee failed to ensure that any restraining that is necessary is done in accordance with the Act and regulations. [s. 29. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that any restraining that is necessary is done in accordance with the Act and regulations, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

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

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. Inspector noted resident #755 had a lap belt which the resident was unable to release. Inspector spoke with two staff members who confirmed the resident is unable to release the physical device. Inspector noted the use of this physical device to restrain the resident was not included in the resident's plan of care. The licensee failed to ensure that the use of a physical device is included in the resident's plan of care. [s. 31. (1)]

2. Inspector noted resident #755 had a lap belt which the resident was unable to release. Inspector reviewed the health care record, including plan of care for resident #755. Inspector was unable to locate any documentation identifying the significant risk that the resident or another person would suffer serious bodily harm if the resident was not restrained. The licensee failed to ensure restraining of a resident is included in the resident's plan of care only if there is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. [s. 31. (2) 1.]

3. Inspector noted resident #755 had a lap belt which the resident was unable to release. Inspector reviewed the health care record, including plan of care for resident #755. Inspector was unable to locate any documentation identifying what alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk. The licensee failed to ensure restraining of a resident is included in the resident's plan of care only if alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk. [s. 31. (2) 2.]

4. Inspector noted resident #755 had a lap belt which the resident was unable to release. Inspector reviewed the health care record, including plan of care for resident #755. Inspector was unable to locate an order by a physician or registered nurse in the extended class approving the restraining of the resident using a physical device. The licensee failed to ensure that restraining of a resident is included in the resident's plan of care only if a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. [s. 31. (2) 4.]

5. Inspector observed resident #747 to have multiple physical devices applied while up in a wheelchair. Inspector noted the resident is physically unable to release these physical devices. Upon reviewed of the resident's health care record no order to use these physical devices as restraints was located. The licensee failed to ensure that

restraining of a resident is including in the resident's plan of care only if a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. [s. 31. (2) 4.]

6. Inspector noted resident #755 had a lap belt which the resident was unable to release. Inspector reviewed the health care record, including plan of care for resident #755. Inspector was unable to locate consent by the resident or a substitute decision-maker. The licensee failed to ensure that restraining of a resident is included in the resident's plan of care only if the restraining of the resident has been consent to by the resident, or if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. [s. 31. (2) 5.]

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 use of a physical device to restrain a resident is included in the resident's plan of care, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. Inspector made the following observations during the inspection:
- review of the home's staffing schedules, for the last three months, shows that on average 32 shifts per month are worked short staffed.
- on January 29, 2013, inspector did a walk-through of the home at 17:30h and found the following resident beds did not have linen on the beds: room 32, room 31 bed 3, room 17 bed 1, room 16 bed 3, and, room 16 bed 4.
- on January 21, 2013, inspector did a walk-through of the home at 17:30h and found the following resident beds did not have linen on the beds: room 30 bed 1 and room 31 bed 2
- on January 29, 2013, resident #747 observed to be very upset because the resident's scheduled tub bath had been canceled,
- on January 29, 2013, resident #707 was observed to be attending the supper meal in the dining room smelling heavily of urine
- on January 29, 2013, inspector observed resident #753 being very upset that staff took a long time to respond to the resident's call for assistance. During this same instance, inspector observed the RPN tell resident: "remember we told you we were busy". Directly after this, staff #100 attending the resident stated: "we are only 2 down this hallway".
- Inspector observed resident #733 on January 21, 2013 at 13:30h, January 24, 2013 at 13:30h and on January 29, 2013 at 15:30h to have food stained shirt and pants,
- on January 21, 2013 at 15:30h, inspector observed resident #700 to be seated in a wheelchair with a tab monitor not attached to the resident,
- on January 21, 2013 at the supper meal, resident #701 observed to leave the dining room abruptly and return to the resident's room. Inspector inquired as to why the resident left the dining room without having had supper and resident replied: " I waited and waited and got so tired. I need to go to bed"
- Inspector noted that throughout the 2 week inspection, resident #747's wheelchair was observed to have a heavily soiled lap belt and that the chair had food stuff on the seat, wheels and battery pack
- on January 23, 2013, resident #733 was observed by inspector to be asleep in the wheel chair while at breakfast, having not eaten anything. No staff assistance was provided until inspector identified the situation to staff
- on January 30, 2013, inspector noted that the call bell for resident #715 was initiated at 13:20h. At 13:45h, inspector investigated the call bell and found that resident had been incontinent and was agitated. With inspector prompting to attend to the resident, staff terminated the call bell at 13:46h (26 minutes)
The licensee failed to ensure staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set

out in the Act and regulations. [s. 31. (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 ensuring the staff plan provides for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and regulations., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. Inspector reviewed the health records for resident #733 and noted that the resident was hospitalized for a significant change in health status. MDS data identified the resident as "incontinence worsening". Inspector reviewed the resident's health record for assessment of continence following the return from hospital and noted that the last recorded assessment of continence is dated December 27, 2011 (2 years ago) and that this assessment still has the status of "in progress". Inspector reviewed the home's policies in regards to its continence care and bowel management. Inspector noted that the policy directs registered staff to complete a continence assessment within Point Click Care and that these are to be completed on admission, with significant change and quarterly. The licensee failed to ensure that a resident who is incontinent receives an assessment that includes identification of causal factors, pattern, type of incontinence and potential to restore function with specific interventions using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require. [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 residents who are incontinence receive a continence assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector reviewed the health care record for resident #755. Inspector noted that progress notes and medication administration records show the resident as having ongoing pain and receiving analgesic for this pain. Inspector was unable to locate a pain assessment, using a clinically appropriate assessment tool, for this resident. Inspector spoke with staff #103 who identified that the home does have pain assessment tools for assessing residents with pain concerns; however these pain assessment tools were not utilized in assessing resident #755's pain. The licensee failed to ensure that when a resident's pain is not relieved by initial interventions, that the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

2. Inspector reviewed the health care record for resident #715. Inspector noted progress notes identify the resident as having increased pain and the resident receiving analgesic for this pain. Inspector was unable to locate a pain assessment tool assessing this resident's increased pain and use of analgesic. Inspector spoke with staff #103 who identified that the home does have pain assessment tools for assessing residents, however these tools have not been used to assess resident #715's pain. The licensee failed to ensure that when a resident's pain is not relieved by initial interventions, that the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring when a resident's pain is not relieved by initial interventions, that the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. It was reported to inspector by staff that resident #747 has responsive behaviours. Upon review of the resident's health care record it was noted that the resident demonstrates significant and on-going responsive behaviours. The resident has not been assessed by any outside resources and the plan of care was noted to only contain generic interventions such as observe and report changes and provide a quiet environment. No assessment tools were located to have been used to assess triggers of the resident's responsive behaviours. No specific strategies have been implemented to help staff respond to the resident's responsive behaviours. Staff #101 identified to the inspector that the home does not have the availability to behaviour support Ontario (BSO) resources. The licensee failed to ensure that a responsive behaviour management program has been developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [s. 53. (3) (a)]

2. In an interview with the inspector, staff #101 confirmed the responsive behaviour program has not as yet been fully implemented within the home. The licensee failed to ensure a responsive behaviour program is developed and implemented in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices. [s. 53. (3) (a)]

Additional Required Actions:

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 a responsive behaviour management program is developed and implemented in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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,
(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; O. Reg. 79/10, s. 87 (2).

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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. Inspector received a complaint that resident's personal care equipment was not kept clean and that this affected the resident's dignity. Throughout the inspection, inspector observed the resident's wheelchair for cleanliness. It was found that the resident's chair was heavily soiled with dried food and crumbs on many surfaces including seat-belt, seat cushion, the sides of the chair, the back of the chair, the battery box and on supporting wheelchair railings. Inspector reviewed the home's night shift duties roster which identified the process for cleaning resident care equipment. The cleaning of resident equipment is identified on this form as a night shift duty. Inspector interviewed staff #104 and staff #105. Both staff confirmed that they have worked night shift and stated that they do not clean resident care equipment on this shift. Both staff concurred that they believed that this was an assigned task to a contract company. Inspector interviewed the Administrator who confirmed that it remains a clear expectation that staff are to clean resident care equipment on night shift. Staff #101 informed inspector that it has been noted on the duty accountability sheets given on a weekly basis to DOC, that staff are not consistently doing this duty. The licensee failed to ensure that procedures are implemented for the cleaning and disinfection of resident care equipment. [s. 87. (2) (b)]

2. On January 22, 2013, during stage one of the RQI process inspector 151 noted a "musky smell in tub room". On January 31, 2013, inspector 106 also noted a musky smell in the tub room. On January 31, 2013, this was brought forward to staff member #101, who stated that they had noted a smell in the tub room as well. The licensee failed to ensure that 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, addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that procedures are implemented for the cleaning and disinfection of resident care equipment, and procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. Inspector noted that the home's abuse policies and procedures are not reflective of the requirements of the Act. Inspector notes the last revision to the policies was May 2008. Inspector notes that the policies are out-dated in the following ways:
- refers to Service Area Office as the Regional Office, Long Term Care Facilities Branch
- refers to Inspectors as Compliance Advisors
- instructs staff to report alleged abuse to the ministry within 5 days
- does not include whistle blowing protection
- does not include the requirement to make mandatory reports
The licensee failed to ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences. [s. 99. (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 ensuring that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (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:
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. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. Inspector observed that resident #747 had multiple physical devices applied to the resident's wheelchair. Inspector noted the resident in unable to independently remove these physical devices. Inspector interviewed staff #101, staff #103 and staff #106 who all confirmed that the home has not applied the restraint policy including hourly monitoring, every 2 hour re-positioning of the resident, observation of the resident's response to the restraint and the provision of documentation for these interventions. Inspector notes that home's staff identify the resident's physical devices as Personal Assistance Service Devices. Inspector reviewed the home's resident/Substitute Decision Maker consent form used and noted the following statement in regards to Personal Assistance Service Device: "...while this device may improve quality of life, it has , as a by-product, restrictive qualities to the freedom of movement of the resident . Thus it referred to as a restraint and is treated as such". The licensee has failed to ensure when a resident is restrained by a physical device, that resident is monitored while restrained at least every hour, by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff. [s. 110. (2) 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 residents, while restrained, are monitored at least every hour, by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

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; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(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. On January 31, 2013, inspector observed deep gouges on the lower wall beside the door at the entrance to room 26. The gouges were in excess of 20 cm in length and the inside of the drywall and a drywall screw was visible. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

WN #15: The Licensee has failed to comply with LTCHA, 2007, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)
(o) information about the Residents' Council, including any information that

may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. Inspector reviewed the home's admission package and was unable to locate information regarding an explanation of whistle-blowing protections related to retaliation. On January 31, 2012, staff #107, reviewed the admission package with the inspector. Staff #107 was unable to locate an explanation of whistle-blowing protection related to retaliation within the admissions package. The licensee failed to ensure that package of information shall include, at a minimum, an explanation of the protections afforded by section 26. [s. 78. (2) (q)]

2. Inspector reviewed the home's admission package and noted no information regarding the resident's ability to have money deposited in a trust account was present. On January 31, 2012, staff #107, reviewed the admission package with the inspector. Staff #107 pointed out in the "Long-term Care home Unfunded Services Agreement" where there is an area that can be checked and initialed to authorize the home to withdraw money from the resident's trust account to pay for unfunded charges. No where in the admission package was any other information found regarding trust accounts or the resident's ability to have money deposited into a trust account, as per O. Reg 79/10, s. 224 (1) 7. The licensee failed to ensure that that the package of information included any other information provided for in the regulations, specifically, information regarding the resident's ability to have money deposited in a trust account. [s. 78. (2) (r)]

WN #16: The Licensee has failed to comply with LTCHA, 2007, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. Inspector was unable to locate information posted within the home relating to the home's minimizing of restraining policy. On January 31, 2013, staff member #101, showed inspector where the information regarding restraint policies is normally posted. On this day there was no information regarding 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 found posted in the home. The licensee failed to ensure the required information regarding 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 is posted and communicated within the home. [s. 79. (3) (g)]

2. Inspector was unable to locate an explanation of the evacuation procedures posted within the home. On January 31,2013, staff member #101 reported to the inspector that there was not an explanation of evacuation procedures posted in the home. The licensee failed to ensure the required information regarding an explanation of evacuation procedures is posted and communicated within the home. [s. 79. (3) (j)]

WN #17: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. In an interview held with the Administrator on January 29, 2013, the Administrator confirmed that the Resident Council was not consulted in the developing of the satisfaction survey. Administrator stated that the survey was developed by an external contracted source, and this was completed without consultation/input from the home. The licensee failed to ensure the home seeks the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. [s. 85. (3)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On January 31, 2013, inspector observed a bottle of extra strength Tylenol in the green unit medication cart. Staff #108 reported to inspector that resident #718 purchases the Tylenol in the community and brings it back to the home and the registered staff then dispenses the medication to to this resident PRN as per doctor's orders. The Administrator provided the inspector with a copy of the home's policy related to medications received from residents or families. The policy states, "Only those medications dispensed from the contracted pharmacy vendor, and or emergency after hour's pharmacy or government pharmacy shall be administered by the Registered Staff Member." The licensee failed to ensure that no drug is acquired, received or stored by or in the home or kept by a resident unless the drug has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. [s. 122. (1)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. In an interview with staff #101 on January 29, 2013, staff #101 confirmed that the home does not maintain a record of the dates improvements were implemented. Upon review of the home's process in regards to quality improvement (QI) the inspector found that records consist mainly of forecasts of QI and risk management goals for the following year. These reports refer to target dates and not actual implementation dates. The licensee failed to ensure the home maintains a record of the names of the person who participated in the evaluations and the dates the improvements were implemented. [s. 228. 4. ii.]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 8 day of May 2013 (A1)

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