(roommate was lying on the bed across from resident). Inspector had to ask for the resident to be covered or the curtain to be pulled. [s. 3. (1) 8.]

3. [LTCHA, 2007, S.O. 2007, c.8, s. 3(1)11.iv]
The home did not have residents' personal health information, within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.
A) On April 11, 203 at 1530 hours the Point of Care (POC) kiosk outside a resident room was open to a resident's file which could be viewed by others. There was no staff at the kiosk or in the hallway at the time. (141)
B) On multiple occasions during the inspection period (March 21, April 5 and 22, 2013) the registered staff did not have the electronic Medication Administration Report (e-mar) laptops logged off when administering medication to residents and the carts were unattended. Patient information was exposed on the screen and visible to visitors who were on the unit. (147)
C) On April 19, 2013 resident #1011 had their personal health information, such as health card number, resident's medical diagnosis and date of birth, attached to the resident's foot board and visible to all who entered the resident's ward room. [s. 3. (1) 11. iv.]

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 with ensuring that residents are properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs, s. 3(1) 4; that residents are afforded privacy in treatment and in caring for their personal needs, s. 3(1)8; and personal health information is kept confidential in accordance with the Act, s. 3(1)11.iv, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 10. Recreational and social activities

Specifically failed to comply with the following:

s. 10. (2) Without restricting the generality of subsection (1), the program shall include services for residents with cognitive impairments, and residents who are unable to leave their rooms. 2007, c. 8, s. 10 (2).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 10(2)]
The recreation and social activities program did not include services that met the needs of residents with cognitive impairments and residents unable to leave their rooms.
A) On numerous days of the inspection multiple residents were lined up in their wheelchairs along the one side of the hallway for several hours per day. This was identified on all floors, however, one floor had a particularly large number of residents sitting in the hallways in their wheelchairs between breakfast and lunch and lunch and the dinner meal. Staff stated that they were getting residents ready for lunch and when questioned (it was 1030 hours and lunch began at 1200 or 1230 hours) staff then stated that staff could supervise the residents in the hallways. Recreation staff and residents confirmed that programming was provided in the resident lounge and not routinely provided for residents in the hallways. Staff also confirmed that residents did not have anything to do while sitting in the hallways. One-to-one programming for residents in their rooms was not consistently provided and goals related to minimum number of programs per month were not identified for residents at risk. The programs provided for at the home did not meet the needs of the residents who were stationed against the walls in the hallways for extended periods of time. [s. 10. (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 with ensuring there is an organized program of recreational and social activities for the home to meet the interests of residents, including services for residents with cognitive impairments, and residents who are unable to leave their rooms, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings

Specifically failed to comply with the following:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care; O. Reg. 79/10, s. 12 (2).
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).
(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).
(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).
(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

1. Resident mattresses were not at least 10.16 centimetres (cm) thick unless contraindicated as set out in the resident's plan of care.
Measurement of the following resident mattresses on the 3rd and 4th floor indicated that the mattresses were between 13 to 15(cm) in depth, however all of the identified mattresses had between 3.5 cm and 7 cm divots in the middle of the mattress which did not ensure that the mattresses were at least 10.16cm in thickness.

A) Resident #1011 - bed had a 6cm divot in the middle of the mattress and the mattress was 13cm deep
B) Resident #1017 - bed had a 6cm divot in the middle of the mattress and the mattress was 14cm deep
C) Resident #1018 - bed had a 6cm divot in the middle of the mattress and the mattress was 13cm deep
D) Resident #1019 - bed had a 3.5cm divot in the middle of the mattress and the mattress was 13cm on left side and 15cm on right side deep
E) Resident #1009 - bed had a 5cm divot in the middle of the mattress and the mattress was 14cm deep
F) Resident #1020 - bed had a 6cm divot in the middle of the mattress and the mattress was 14cm deep
G) Resident #8502 - bed had a 7cm divot in the middle of the mattress and the mattress was 15cm deep
H) Resident #1021 - bed had a 5cm divot in the middle of the mattress and the mattress was 13cm deep
I) Resident #8495 - bed had a 6.75 cm divot in the middle of the mattress and the mattress was 13cm deep
J) Resident #1022 - bed had a 5.5cm divot in the middle of the mattress and the mattress was 15cm deep [s. 12. (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 with ensuring that resident beds have firm, comfortable mattresses that are at least 10.16 cm thick unless contraindicated as set out in a resident's plan of care, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (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. [LTCHA, 2007, S.O. 2007, c.8, s. 15(2)(a)]
The home, furnishings, and equipment were not kept clean and sanitary.
A) The kitchen was not clean and sanitary on April 5, 2013. Accumulated debris was identified underneath the fixed steam table, stoves, fryers, plate storage area and under the back corner of the stainless steel tables located along the windows. Accumulated dust and grease was identified on the exhaust hood filters and the filter for the exhaust over the dishwasher. (120)
B) The main floor dining room ceiling had a heavy accumulation of dust on the ceiling around the ceiling fans between April 2 and 5th, 2013. (120)
C) The interior upper and lower cabinets in a dining room were soiled between April 2 and 5th, 2013. (120)
D) April 19, 2013 at 1219 hours the toilet in a tub and shower room on one floor was dirty with feces in the toilet. The room was not in use (door locked, lights off). Staff called housekeeping to have the area cleaned when identified by the inspector. (147)
[s. 15. (2) (a)]

2. [LTCHA, 2007, S.O. 2007, c.8, s. 15(2)(c)]
The home, furnishings and equipment were not maintained in a safe condition and in a good state of repair.
A) Furnishings provided to residents by the home, specifically night tables and bathroom vanity counters, were not in a good state of repair and some were not maintained in a safe condition. Night tables identified but not limited to rooms ten rooms and a wardrobe in one room all had exposed particle board edges on the top surface. Night tables in two identified rooms had surfaces that presented the greatest risk for skin tears and splinters.
B) Vanity counter tops identified but not limited to three resident en-suite washrooms, were observed to be lifting in one section (curved area). The skirting just under the counter top in an identified bathroom was jagged, rough and very sharp and presented a risk for injury. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the home, furnishings and equipment are kept clean and sanitary, s. 15(2)(a); and the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, s. 15 (2)(c), to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16.

Findings/Faits saillants :

1. Outdoor windows accessible to residents, specifically those identified in the main floor dining room and lounge, were not restricted to 15 centimeters (cm).

At least three large windows in the main floor lounge and 3 large windows in the main floor dining room were unrestricted and could be opened wider than 15 cm. Other windows in these rooms had a screw set into the interior section of the sliding window frames preventing them from opening wider than 15 cm. [s. 16.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 10 cm, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The resident-staff communication and response system did not include points of activation in every area accessible by residents. The main floor dining room, activity room, lounge 2nd, 3rd and 4th floor sitting rooms did not have activation stations installed and therefore, residents were not able to activate the system from these areas. [s. 17. (1) (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents, s. 17(1)(e), to be implemented voluntarily.

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table.

Findings/Faits saillants :

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1. The lighting requirements set out in the lighting table were not maintained.

Some areas of the home were measured with a light meter on April 3 and 5th, 2013. The meter was held at waist height, with the light source either above or in front of the meter. The following lux levels were identified;

East Stairwell

Outside the 3rd floor stairwell door, 0 lux, under the fluorescent light
Outside the 2nd floor stairwell door, 50 lux under the fluorescent light
Outside the 1st floor stairwell door, 0 lux, under the fluorescent light
Zero lux while walking up or down the stairs
2nd and 3rd floor landing - 90 lux

West Stairwell

Outside the 3rd floor stairwell door, 20 lux under the fluorescent light
Outside the 2nd floor stairwell door, 90 lux under the fluorescent light
Outside the 1st floor stairwell door, 20 lux under the fluorescent light
2nd floor landing, 90 lux
3rd floor landing, 150 lux
Zero lux while walking up or down the stairs.

The required level of illumination for stairwells is a continuous consistent lux of 322.92.

* First floor corridor (towards dining room) - Many fluorescent light tubes were noted to be flickering and the entire light fixture was measured to be 40 lux. When reported to the management of the home, the light tubes were replaced on one fixture and the illumination levels increased to 500 lux. The fixtures are spaced 12 feet apart and the level of illumination between fixtures was approximately 50 lux. A continuous consistent lux of 215.28 is required.

* Third floor corridors (east and west) - The area between the east and west corridors is poorly lit, with fluorescent light fixtures above the nurses' station and in the lounge area which is connected to the corridor. A small fluorescent tube is provided above the elevator doors. The area spans approximately 35 feet and throughout this

distance, the lux available was 0-10. Some of the corridor fluorescent light fixtures were measured at 500 lux directly under the light and 150 lux between fixtures. Fluorescent light fixtures in front of two identified rooms were flickering and measured 75 lux. Fixtures are spaced 8 or 12 feet apart, depending on the corridor. A continuous consistent lux of 215.28 is required.

* Fourth floor corridor - Light fixtures were noted to be 90 lux in front of the elevators and above the nurse's station. When the tubes were replaced, the levels increased to 600 lux. The fixtures in front of three identified rooms were 400 lux, 200 lux and 80 lux. The light fixtures are spaced 8 feet apart between two identified rooms and were measured at 10 lux. A continuous consistent lux of 215.28 is required.

* Resident bedrooms - no light fixtures have been provided for the rooms in general. Each resident has their own over bed light. Tested one four bed room. One window had curtains drawn and the other was open and it was overcast outside. When standing in the centre of the room, the levels of illumination was 0-10 lux. No over bed lights were on. A lux of 215.84 is required for bedrooms which is considered "other area" in the lighting table.

* Third floor shower room - 10 lux over the toilet area, 50 lux directly under the light over the sink.
* Fourth floor shower room - 0 lux under shower fixture, 190 lux directly under the ceiling light (which is not centered over the shower area) and 160 lux over the toilet area.
* Fourth floor tub room - 90 lux under the light in the shower area.
* Bathroom in an identified room - 90 lux in the centre of the room
* Bathroom in an identified room - 150 lux in the centre of the room

A lux of 215.84 is required for showers, tub rooms and bathrooms which is considered an "other area" in the lighting table. [s. 18.]

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 with ensuring that the lighting requirements set out in the Table to this section are maintained, to be implemented voluntarily.

WN #23: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (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).

Findings/Faits saillants :

1. Residents #1004 and #1005 did not have an order for the use of two full length bed rails as a restraint when in bed. The residents were observed in bed with two full bed rails in place on April 15, 2013. Staff confirmed the residents utilized the bed rails for safety and the rails were considered a restraint. The consents signed by the POAs identified the full bed rails as a restraint. There were no physician orders currently in place to identify the need to use the full length bed rails as a restraint for the two residents. [s. 31. (2) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining, to be implemented voluntarily.

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Staff did not use safe transferring and positioning devices or techniques when assisting resident #0812. The resident was on the toilet while remaining attached to a sit/stand lift on March 21, 2013 in a tub room. There was no staff in attendance in the room. The door to the room was shut but not locked. A PSW who was found attending to the care of another resident confirmed they had left the resident on the toilet unattended. The home's policy and procedure "Minimal Lift Resident Handling program" stated the resident must be able to partially weight bear and be able to move from a supine position to a sitting position and balance in a sitting position on the edge of the bed when using a sit/stand lift. When the sit/stand lift is used for transferring a resident for toileting the resident is not to be left unattended. The Administrator confirmed the resident should not have been left unattended or attached to the sit/stand lift while on the toilet. [s. 36.]

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 with ensuring that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Protocols for the referral of residents to specialized resources were not developed to meet the needs of residents with responsive behaviours.
A) Resident #8578 was not referred to a specialized resource for the responsive behaviours associated with depression. The resident was seen by a specialist and the consultation summary stated the resident was to be followed by the Occupational Therapist from their outside resource group. The resident had further contributing factors for the depression after this assessment and continued to express feelings of sadness. Six months later, the resident was initiated on medication. The resident was not followed by the outside Occupational Therapist after the initial consult and no referral to a specialized resource was completed at the time of change in resident's responsive behaviours.
B) Resident #1006 was not referred to a specialized resource for responsive behaviours of physical aggression. Documentation in the resident's progress notes identified the resident had five episodes of physical aggression in 2012 and three episodes in 2013 that resulted in an outside agency being called into the home. The resident had been assessed by a specialist, however, there was no further follow up although the consultation report stated the outside resource would follow. There was no subsequent referral to the specialized resource completed in 2012 or 2013 for continued exhibited responsive behaviours. [s. 53. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring the development of protocols for the referral of residents to specialized resources where required, to meet the needs of residents with responsive behaviours, to be implemented voluntarily.

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 54(a)(b)]
Steps were not taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including the identification and implementation of interventions for resident #1006. The resident's progress notes identified five incidents of responsive behaviours in 2012 and three incidents in 2013. All behaviours resulted in an outside agency being called into the home. An assessment was not completed related to the responsive behaviour. An assessment that included screening tools, DOS charting, assessment by the physician, identification of the triggers for the behaviour, and referral to Behaviour Support Team and specialized outside resources, was not completed. The DOC confirmed that an assessment of the responsive behaviour should have been completed, including DOS charting and referrals. [s. 54.]

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 with ensuring that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and identifying and implementing interventions, s. 54(a)(b), to be implemented voluntarily.

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, 65(2)(f)]
The recreation program did not include assistance and support to permit residents to go on outings and participate in activities that were of interest to them if they were not able to do so independently.
A) A ratio of one staff member and one volunteer were assigned to accompany up to 15 residents on outings outside of the long-term care home. Staff confirmed that staffing levels for outings were not based on an assessment of resident needs and abilities. Concerns about safety and meeting resident needs were identified in the Recreation department meeting minutes and through multiple interviews with recreation staff. Review of resident care needs based on resident attendance on two outings reflected insufficient staffing to meet the needs of the residents attending the outings.
i) An outing was planned with 1 Recreation Aide, 1 volunteer, 13 nursing home (NH) residents and 2 retirement home (RH) residents. All of the NH residents attending the outing were at risk for falling, four residents required staff assistance with toileting, 2 residents had a history of physical/verbal aggression, 1 resident consistently would get up out of their wheelchair (falls risk) unless constantly supervised, and 3 residents had wandering behaviour. Multiple staff members identified an incident where two residents wandered away while residents were being assisted with toileting.
ii) An outing was planned with 1 Recreation Aide, 1 volunteer, 7 NH residents and 1 RH resident. Care planning and staff interview identified substance seeking behaviour of one resident attending the outing, 1 resident who wandered/exit seeking, 1 resident who constantly tried to get out of their wheelchair unless consistently supervised, 2 residents with verbal/physical aggression and 4 residents who required extensive toileting assistance. Staff identified that a male resident had to be brought to the female washroom for supervision while the female residents were being assisted with toileting.
iii) Management staff identified that training on transferring and toileting techniques had been completed (not recently), however, documentation to support that training had been provided to Recreation Aides was not available. [s. 65. (2) (f)]

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 with ensuring the recreational and social activities program for the home includes assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently, to be implemented voluntarily.

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

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

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 71(3)(c)]
Not all residents were offered a snack at the afternoon snack pass April 16, 2013. Residents requiring thickened fluids and those requiring a pureed menu were also not offered a snack. Seven identified residents were not offered a snack (Resident #1012, #1010, #0812, #5581, #1013, #2144, #1023/#1024). Staff confirmed that a snack was not offered to residents requiring thickened fluids or pureed menus. [s. 71. (3) (c)]

2. [O.Reg. 79/10, s. 71(4)]
A) The planned menu items were not available for the afternoon snack pass April 16, 2013. The planned menu identified pureed blueberry cake, however, this was not available on the snack cart and not offered to residents. Residents who required a pureed menu were not offered a snack. Thickened fluids were not available on the snack cart and nursing staff obtained a jug of thickened juice from the medication room for the cart. Alternative thickened fluids were not available for residents requiring thickened fluids and the correct consistency of thickened fluids was not available for residents requiring different consistencies of thickened fluids. The Food Services Manager confirmed that different consistencies of thickened fluids were required for the snack cart on that floor.
B) The planned menu items were not available for the afternoon snack pass April 18, 2013. The planned menu identified cruellers and pureed cruellers, however, cookies were provided for the regular texture and a pureed snack was not available. Staff confirmed that only the labeled snacks of jello, pudding or ice cream were available for residents who required pureed snacks and if they did not have a labeled snack there was no alternative. Four residents who required a pureed snack did not have a planned special labeled snack. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that each resident is offered a snack in the afternoon and evening, s. 71(3)(c), and that the planned menu items are offered and available at each meal and snack, s. 71(4), to be implemented voluntarily.

WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 72(3)(a)]
Not all foods were served to residents using methods which preserved taste, nutritive value, appearance and food quality.
A) Staff assisting resident #8471 with eating at the lunch meal March 21, 2013 mixed the resident's pureed food items together on the plate. The staff member stated the resident disliked one of the items so they were mixing it together to try to get the resident to eat the item. The food was not served in a way that preserved the taste of each item being served (mixed together so cannot taste the individual flavour), and foods the resident disliked were now mixed into the entire meal, resulting in altered taste of the foods the item was mixed with. Staff were also observed mixing texture modified foods together on the spoon or plate at the supper meal April 16, 2013, for two identified residents (Resident #1754, #1025). (107)
B) On March 21, 2013, residents #1002, #8447, and #5581 were fed by staff who mixed the altered textured vegetable, protein and starch together on the spoon before providing the food to the resident. Resident #4592 was fed by staff who mixed the regular textured vegetable, protein and starch on a fork before providing the food to the resident. Resident #8448 was fed by staff who mixed altered textured food on a fork before providing the food to the resident. Residents' plans of care did not identify the requirement or resident preference for mixing of food types prior to feeding. (141)
C) The texture of the minced meat for the salad plate served at the lunch meal March 21, 2013 did not preserve taste, nutritive value, appearance and food quality. The meat had a large amount of thickener added to it, affecting the taste, appearance, and nutritive value. The product resembled a scoop of gel with a few specks of meat throughout and the taste was unpalatable. Staff acknowledged the product was not visually appealing and contained a large amount of thickener. (107)
D) The texture of some pureed food items was too runny, resulting in reduced nutritive value as the nutritive value was diluted with additional fluid. At the lunch meal March 21, 2013, the pureed hashbrowns, pureed mixed vegetables, and the minced mixed vegetables were noted to be too runny and did not hold their form on the plate. The items were noted to be running into each other on the plate. (107)
E) Staff portioning foods at the lunch meal March 21, 2013 were observed using the same scoop for multiple items of the same texture. The appearance and taste of the foods were not maintained with residue from each item being added to the next item. (107)
F) A resident poured their honey thickened (cold) water on top of their (hot) meal at the supper meal April 16, 2013, resulting in altered taste and temperature and staff did not get the resident a fresh meal. The resident was not able to voice their preferences

when asked by the inspector. (107) [s. 72. (3) (a)]

2. [O.Reg. 79/10, s. 72(3)(b)]
Not all foods were served using methods that prevented adulteration at the lunch meal March 21, 2013.
A) Staff portioning the meal were using the same scoops for the minced and pureed textured mixed vegetables and minced and pureed texture tomato/cucumber mixture. This created a risk for choking for residents requiring pureed texture as pieces of minced food are transferred to the pureed textured foods.
B) Dry goods stored in bins were not stored in a manner that prevented contamination. Scoops for portioning oats, cornmeal and skim milk powder were stored inside the bins of food, creating a risk for contamination of the entire bin of food. [s. 72. (3) (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 with ensuring that all food and fluids int the food production system are prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality, s. 73(2)(a), and prevent adulteration, contamination and food borne illness, s. 72(3)(b), to be implemented voluntarily.

WN #30: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (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. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 76(2)]
At the time of this inspection, staff were unable to demonstrate that an orientation program was provided to agency staff working at the home. The home's policy indicated that an orientation checklist would be completed and signed by the employee and manager and become part of the personnel file, however, management confirmed that they do not currently keep records related to completion of staff orientation. Concerns about a staff member's conduct were identified during this inspection and information provided did not support that an orientation had been provided to the staff member. [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 with ensuring that no staff perform their responsibilities before receiving training in the required areas, to be implemented voluntarily.

WN #31: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 78(2)(c)(d)(e)(n)(q)]
Review of the admission packages provided by the business manager, and the five resident admission files reviewed, demonstrated that the admission packages did not include:
A) The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
B) An explanation of the duty to make mandatory reports related to incidents resulting in harm or risk of harm to a resident, such as:
* improper or incompetent treatment or care of a resident
* abuse by anyone or neglect by the licensee or staff
* unlawful conduct
* misuse or misappropriation of a resident's money
* misuse or misappropriation of funding provided to the licensee
C) The long-term care home's procedure for initiating complaints to the licensee.
D) Disclosure of any non-arm's length relationships that exist between the licensee and other providers who offer care, services, programs or goods to residents.
E) An explanation of whistle-blowing protections related to retaliation. [s. 78. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the home's admission package includes the required information, s. 78(2)(c)(d)(e)(n)(q), to be implemented voluntarily.

WN #32: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (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. [LTCHA, 2007, S.O. 2007, c.8, s. 79(3)(c)(e)(g)(h)(p)]
The following required information was not posted in the home, in a conspicuous and easily accessible location in a manner:
A) The policy to promote zero tolerance of abuse and neglect of residents was not posted and communicated;
B) The procedures for initiating complaints to the licensee was not posted and communicated;
C) The policy to minimize the restraining of residents was not posted and communicated;
D) The name and telephone number of the licensee was not posted; and
E) The home did not have an explanation of whistle-blowing protections related to retaliation posted and communicated. [s. 79. (3) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring the required information is posted in the home, s. 79(3)(c)(e)(g)(h)(p), to be implemented voluntarily.

WN #33: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

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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,
(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; 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,
(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).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 87(2)(a)]
Although housekeeping procedures were developed for the cleaning of soiled utility rooms, the procedures lacked information for staff to ensure that the dishwasher, hopper, cabinets, counters, contact surfaces and wall surfaces were cleaned and disinfected as frequently as required for the activities that take place within it.

All three soiled utility rooms in the home, over three days of the inspection, were overly congested and not conducive for staff to clean and disinfect resident's personal care articles. The home's infection control policy IC-02 directed staff to use these rooms because they had a hopper and a dishwasher where personal care articles were to be cleaned. Staff used the hopper to clean soiled articles (where fecal material can be aerosolized) and then load the dishwasher. Once the articles were removed from the dishwasher, the articles were to be sprayed with disinfectant and allowed to air dry. The counter top was therefore an area that must be clean and clear to allow this activity to occur.

The counter tops were dusty and cluttered with recycling boxes, plastic articles and various objects. The cabinet upper and lower interiors were observed to be unclean and contained soiled plastic personal care items (bed pans, washbasins), commode pots, resident's personal affects, wheelchair foot rests, water jugs, glass vases, and bowel management products.

The risk of cross contamination to the various articles in the room was very likely if staff were directed to use the hoppers and then to use the same room to store clean or just cleaned items. The frequency for cleaning these rooms therefore needed to be increased and all surfaces cleaned and disinfected daily. [s. 87. (2) (a)]

2. [O.Reg. 79/10, s. 87(2)(b)]
The home had developed cleaning and disinfection procedures for the cleaning and disinfecting of resident care equipment, however, not all staff were implementing the procedures.

The home's infection control policy IC-02 dated November 30, 2006 related to several procedures for the cleaning and disinfection of bed pans, urinals, washbasins, kidney basins and denture cups. The procedures required staff to spray disinfectant onto the articles after removing them from the dishwasher and to allow them to air dry. The process was to be completed in the soiled utility room.

A cart full of wet basins, kidney basins and denture cups was parked in a corridor on April 2, 2013. A staff member was seen wiping the articles with a towel. According to the worker, the items were just removed from the dishwasher located in the soiled utility room. The staff member explained that the articles were just removed from the dishwasher but they could not confirm whether the items were disinfected. The worker returned to the cart a few minutes later with a disinfectant spray bottle and began spraying the items in the corridor. The disinfectant was not used appropriately as it was not left on the items for a minimum of 1 minute as per manufacturer's instructions or allowed to air dry as per the home's procedures. [s. 87. (2) (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 with s. 87(2)(a),(b), to be implemented voluntarily.

WN #34: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 101(2)]
The licensee did not ensure that a documented record was kept in the home that included all actions taken to resolve complaints, including the date of the action, the final resolution, if any, and the response to the complainant including the date and time.
Review of the home's Occurrence Log was completed for 15 individual complaints since February 2012. Nine of the fifteen logs did not include a record of the responses to the complainant, including dates and a description of the response. Seven of the fifteen logs did not include actions taken for each component of the complaint, including dates. [s. 101. (2)]

2. [O.Reg. 79/10, s. 101(3)(a)(b)(c)]
The home was not able to provide documented evidence of a quarterly review of the complaints received by the home. The Administrator confirmed the home was not reviewing the complaint record quarterly to analyze for trends and that a written record was not kept of any reviews and improvements made in response to trends in the complaints received. According to the Administrator, a formalized process for the quarterly review and analysis of complaints received by the home, and documentation to support that the review and analysis occurred, was not in place. (141) [s. 101. (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 with ensuring a documented record is kept in the home that includes the required information related to complaints received by the home, s. 101(2); and that the documented record is reviewed and analyzed for trends at least quarterly, the results of the review and analysis are taken into account in determining what improvements are required in the home, and a written record is kept of each review and of the improvements made in response, s. 101(3), to be implemented voluntarily.

WN #35: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. Section 4.1 under Schedule C of the Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration Network (LHIN) under the Local Health System Integration Act, 2006, reads, "The Health Service Provider shall use the funding allocated for an Envelope for the use set out in the Applicable Policy". The Long-Term Care Homes Funding Policy of July 1, 2010 for Eligible Expenditures for Long-Term Care Homes Program and Support Services (PSS) Envelope Section 1. a) and b) read, "support services and programs are required under the Long-Term Care Homes Act, 2007, are in the schedule of recreation and social activities, or are assessed in a care plan or plan of care to benefit the maintenance or improvement of the level of functioning of residents with regard to the activities of daily living and/or improve the quality of life of residents" and "the time spent by PSS staff to assess, plan, provide, evaluate, and document the support services and programs being provided are included"

A) Recreation staff from the PSS envelope were completing Food Service Worker/Housekeeping duties at the dinner meal service April 16, 2013 in the main dining room. Recreation staff were observed portioning beverages, setting and clearing tables, and cleaning floors and tables during and after the meal service. Staff confirmed these tasks were completed by recreation staff at three meals daily, seven days per week. During interview, recreation staff also stated that they prepared thickened fluids if residents required beverages that were not already prepared by dietary staff and on the fluid cart.
B) Recreation staff were required to staff the front desk during their duties as recreation staff. Staff confirmed that recreation aides were required to cover the front desk over a 40 minute period during the weekend shifts. This was recently changed and staff were covering a 20 minute break in the morning and 1.25 hours in the afternoon on the weekend shifts. General administrative services are not included in the PSS envelope.
C) Staff working in the Retirement Home were paid from the Long-Term Care home funding envelope, according to the home's payroll information ("Wage Distribution by G/L Account", "Wage Distribution by Employee" and "Payroll Register" reports) and staffing schedules for the periods of March 18-31, April 1-28, 2013.
i) The Administrator confirmed that all Recreation hours for both the NH and the RH were being paid from the NH funding envelope.
ii) Two staff members working hours in the Retirement home in one department were paid from the Nursing Home funding envelopes for the pay period of April 1-14, 2013. A staff member worked 26 paid hours in the nursing home (NH) and 22.50 paid hours

in the retirement home (RH) according to the staffing schedule, however, both hours were charged to the NH. A different staff member worked 41 paid hours in the NH and 22.50 paid hours in the RH, according to the staffing schedule, however, both hours were charged to the NH.
iii) A staff member working hours in the Retirement home in one department was paid from the Nursing Home funding envelope for the pay period of April 15-28, 2013. A different staff member worked 35.5 paid hours in the NH and 15 paid hours in the RH, according to the staffing schedule, however, both hours were charged to the NH.
iv) Hours for the Recreation Manager and Dietary Manager were charged to the NH, however, the staff attend meetings, complete scheduling for Recreation, and ordering/inventory for Dietary Services in the RH. [s. 101. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring the home complies with the conditions to which the license is subject, to be implemented voluntarily.

WN #36: 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).

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:
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).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 110(2)3]
Resident #1004 was not monitored at least every hour by a member of the nursing staff while being restrained by two full length bed rails when in bed. The plan of care identified the use of the two full length bed rails and the DOC confirmed the bed rails were in place as a restraint. The Point of Care (POC) documentation reviewed for April 14 and 15, 2013, did not include hourly monitoring of the restraint. The POC did not include an icon for hourly monitoring documentation. [s. 110. (2) 3.]

2. [O.Reg. 79/10, s. 110(2)6]
Resident #1004 and #1005 did not have their condition reassessed and the effectiveness of the restraining by two full length bed rails evaluated at least every eight hours by registered nursing staff or physician. There was no documentation or template identified in the residents' records of an evaluation of the restraints. The DOC confirmed that reassessments of the effectiveness of the restraints were not being completed at least every 8 hours. [s. 110. (2) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that when a resident is being restrained by a physical device, 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, s. 110(2)3; and 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, s. 110(2)6, to be implemented voluntarily.

WN #37: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
1. The resident's ability under subsection 82 (2) of this Regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1). O. Reg. 79/10, s. 224 (1).

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
8. The Ministry's toll-free telephone number for making complaints about homes and its hours of service. O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

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1. [O.Reg. 79/10, s. 224(1)1,8]
For the purpose of clause 78(2)(r) of the Act, the licensee did not ensure that the package of information provided for in section 78 of the Act included information about the following:
A) The resident's ability under subsection 82(2) of this Regulation to retain a physician or registered nurse of the extended class to perform the services required under subsection 82(1).
B) The Ministry's toll-free telephone number for making complaints about homes and its hours of service.

Review of five resident admission packages and interview with the Wellness Coordinator indicated that the admission packages did not include the required information. [s. 224. (1) 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 with ensuring the admission package includes information about the resident's ability under subsection 82(2) of this Regulation to retain a physician or registered nurse in the extended class to preform the services required under subsection 82(1), s. 224(1)1; and the Ministry's toll-free telephone number for making complaints about homes and its hours of service, s. 224(1)8, to be implemented voluntarily.

WN #38: 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. [O.Reg. 79/10, s. 228.3]
Quality initiatives discussed at the Quality meetings were not communicated to the Residents' Council at their meetings. Interview with two members of the Residents' Council and interview with the staff person assisting the Residents' Council confirmed that quality initiatives that were not maintenance related were not discussed at the Residents' Council meetings. Documentation from the Residents' Council meetings did not include reference to discussions related to the home's quality initiatives. [s. 228. 3.]

2. [O.Reg. 79/10, s. 228.4.i]
The home did not maintain a record setting out the improvements made to the quality of the accommodation, care, services, programs, and goods provided to residents. Annual program evaluations identified "next steps" and "areas for improvements, however, a record outlining the improvements made to address the areas of concern was not available. [s. 228. 4. i.]

3. [O.Reg. 79/10, s. 228.4.ii]
The home did not maintain a record of the names of the persons who participated in the program evaluations and the dates improvements were implemented. The Annual program evaluations provided to the inspector did not contain a record of those staff who participated in the evaluations, specific dates the evaluations occurred, and any dates improvements were implemented. Annual Program evaluations were provided for the Skin/Wound Care program, the Infection Prevention & Control program and the Training & Orientation program. [s. 228. 4. ii.]

4. [O.Reg. 79/10, s. 228.4.iii]
Improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents were not discussed with the Residents' Council and a record of any communication of any improvements to the Council was not available. Staff confirmed that formal discussion with the Council in relation to improvements in the quality of the accommodation, care, services, programs and goods provided to the residents did not occur. [s. 228. 4. iii.]

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 with ensuring that the improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents is communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis, (s. 228.3); and that a record is maintained setting out the matters referred to in paragraph 3, the names of the persons who participated in evaluations, and the dates improvements were implemented, and the communications under paragraph 3, (s. 228.4.i,ii,iii), to be implemented voluntarily.

WN #39: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 229(4)]
Not all staff participated in the implementation of the infection prevention and control program.
A) At the afternoon snack service April 16, 2013, staff did not sanitize their hands between assisting residents with feeding and providing snacks to other residents. (107)
B) Storage of items on the snack cart April 16, 2013 did not prevent cross-contamination of soiled and clean items on the cart. Dirty cups and napkins were stored on a flat tray (some were falling over) on the bottom shelf of the snack cart with a box of cookies and clean glasses stored right beside each other. (107)
C) On April 22, 2013 at 1536 hours, a consulting nurse that was contracted to administer a treatment to a resident with an infection, was walking between the resident's room and the nursing station unit wearing full personal protective equipment (PPE). The nurse was exposing and contaminating the nursing station area and by handling nursing equipment, such as the blood pressure machine. The community nurse was not re-instructed by the home's staff until identified by the inspector. (147) [s. 229. (4)]

2. [O.Reg. 79/10, s. 229(10)1]
Not all residents admitted to the home were screened for tuberculosis within 14 days of admission unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of the screening were available to the licensee.
A)One out of five residents reviewed was not screened for tuberculosis within 14 day of admission. Resident #8447 was admitted to the home, review of the resident's health records and interview with the Infection Control Lead confirmed that the resident was not screened for tuberculosis within 14 days of admission and there is no documented evidence to substantiate that the resident had already been screened 90 days prior to admission to the home. [s. 229. (10) 1.]

3. [O.Reg. 79/10, s. 229(10)3]
Residents #8447, #1008 and #8471 were not offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. Three of five resident electronic health records, (#8447, #1008 and #8471), reviewed for immunization against pneumoccocus, tetanus and diphtheria did not receive or were not offered immunization in accordance with the publicly funded immunization schedules posted

on the Ministry website. Interview with the Infection Control Lead confirmed that the immunizations were not offered. [s. 229. (10) 3.]

4. [O.Reg. 79/10, s. 229(10)4]
Not all staff were screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
Review of the home's staff personnel file and interview with the Infection Control Lead confirmed that two out of five staff records did not have their Diphtheria immunization completed after their hire date and one out of five staff members had diphtheria immunization in March 2000 with no documentation to substantiate a booster dose was given after ten years. [s. 229. (10) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that all staff participate in the implementation of the infection prevention and control program (s. 229(4)); that each resident admitted to the home is screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee (s. 229(10)1); that residents are offered immunizations against pneumoccocus, tetanus and diptheria in accordance with the publicly funded immunization schedules posted on the Ministry website (s. 229(10)3); and staff are screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices (s. 229(10)4), to be implemented voluntarily.

WN #40: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 85(4)(a)]
The licensee did not document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey. Documentation did not include evidence that the satisfaction survey results were shared with the Residents' Council and staff confirmed the 2012 survey results were not shared with the Council. [s. 85. (4) (a)]

2. [O.Reg. 79/10, s. 85(4)(b)]
Actions taken to improve the long-term care home, based on the results of the survey were not documented and made available to the Residents' Council. Residents' Council meeting minutes and staff and resident interview confirmed that actions taken to improve the long-term care home were not discussed with the Council. [s. 85. (4) (b)]

3. [O.Reg. 79/10, s. 85(4)(c)]
Survey results and actions taken to improve the home, were not made available to residents and their families. Staff confirmed that the 2012 survey results and action taken were not provided to residents and families due to the low return rate. [s. 85. (4) (c)]

WN #41: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The home's interdisciplinary team did not meet annually to evaluate the effectiveness of the medication management system in the home and recommend any changes necessary. There was no documentation in the home to support that the an evaluation had been completed. The DOC confirmed that a evaluation of the medication management system had not been completed. [s. 116. (1)]

Issued on this 1st day of August, 2013

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

M Warrener, RD