



**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
Performance Improvement and Compliance Branch**

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

Public Copy/Copie du public

**Name of Inspector (ID #) /
Nom de l'inspecteur (No) :** MICHELLE WARRENER (107), BERNADETTE SUSNIK
(120), LALEH NEWELL (147), SHARLEE MCNALLY
(141)

**Inspection No. /
No de l'inspection :** 2013_191107_0005

**Log No. /
Registre no:** H-000159-13

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

**Report Date(s) /
Date(s) du Rapport :** Jun 20, 2013

**Licensee /
Titulaire de permis :** TYNDALL NURSING HOME LIMITED
1060 EGLINTON AVENUE EAST, MISSISSAUGA, ON,
L4W-1K3

**LTC Home /
Foyer de SLD :** TYNDALL NURSING HOME
1060 EGLINTON AVENUE EAST, MISSISSAUGA, ON,
L4W-1K3

**Name of Administrator /
Nom de l'administratrice
ou de l'administrateur :** Patricia Bedord



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To TYNDALL NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:



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Order # / Ordre no : 001	Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)
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Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan that ensures the care set out in the plan of care is provided to residents, including residents #1012, 5581, 1013, 1014, 1015, 1016, 2144, 9951, 8509, as specified in the plan, related to diet order, consistency of thickened fluids, special dietary requirements, and the administration of protein powder.

The plan is to be submitted by July 5, 2013 to Long Term Care Homes Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :



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1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)]

Care was not provided according to residents' plans of care at the afternoon snack pass April 16, 2013.

A) Thickened fluids were not available as required on the snack cart when the snack service began. A jug of one consistency of thickened fluids was obtained from the nursing cart and used for the snack pass, however, residents requiring different consistencies of thickened fluids were not offered the correct consistency of thickened fluids. Staff confirmed that there were residents on that floor that required a different consistency of thickened fluids than what was provided on the snack cart.

i) Residents #1012, #5581, and #1013 required thickened fluids, however, were provided a different consistency of thickened fluids than what was indicated on their prescribed diet order.

ii) Resident #1014 required thickened fluids, however, was provided thin fluids.

iii) Resident #1015 required thickened fluids and was provided thin fluids.

B) Sugar instead of sweetener was provided for two residents with diabetes (not requested or indicated as a preference in their plans of care): Residents #1016, #1014

C) Resident # 2144 did not require thickened fluids, however, thickened fluids were provided in addition to a glass of thin fluids. Staff stated that "sometimes they takes thick fluids and sometimes they takes thin fluids so I gave them both". The resident did not take more than two teaspoons (tsp) of the thickened fluids before refusing.

D) Resident #9951 required a straw for fluids, however, a straw was not provided. (107)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2013



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Order # / Ordre no : 002	Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)
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Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,

- (a) shall provide that abuse and neglect are not to be tolerated;
- (b) shall clearly set out what constitutes abuse and neglect;
- (c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
- (d) shall contain an explanation of the duty under section 24 to make mandatory reports;
- (e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
- (f) shall set out the consequences for those who abuse or neglect residents;
- (g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
- (h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Order / Ordre :

The licensee shall develop, implement, and educate staff on a policy to promote zero tolerance of abuse and neglect of residents, and that policy shall include all of the required elements listed under (a) through (h).

Grounds / Motifs :



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1. The policy to promote zero tolerance of abuse and neglect of residents, at a minimum, did not comply with requirements respecting the matters provided for in clauses (a) through (f) that were provided for in the regulations.

Review of the home's "Abuse" policy with an original date of 1996, current issue date of December 15, 2006, and last reviewed on March, 2008, and interview with the DOC, confirmed that the current policy did not comply with requirements respecting the matters provided for in clauses (a) through (f) that were provided for in the regulation.

The policy did not clearly set out: what constituted sexual abuse; a program that complied with the regulation for preventing abuse and neglect; any explanation of the duty under section 24 to make mandatory reports; and did not set out the consequences for those who abused or neglected residents. (147)

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Order # / Ordre no : 003	Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)
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Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall develop/revise and implement policies for each required program specified in the Act. The policies shall direct staff in the provision of care to residents. The policies must be in compliance with and implemented in accordance with applicable requirements under the Act and complied with by staff providing care.

Grounds / Motifs :

1. [O.Reg. 79/10, s. 8(1)(a)]

The nursing and nutrition and hydration programs did not include systems to ensure the home's policies and procedures were current and relevant. Many of the home's policies had not been reviewed since 2005, 2008, and/or not revised since the 1990's, and were not revised to reflect legislative changes with the LTCHA, 2007 in 2010. The home was purchased by a new licensee one year prior, however, policies that reflected the new owner's practices were not implemented by the home. Direction through policy was not clearly provided to staff providing care to residents.

Nursing examples:

Review of the home's Infection Control Manual interview with the Director of Care confirmed that the home's policy and procedures were not in compliance with and implemented in accordance with applicable requirements under the



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Act.

A) The Infection Control Policies were dated back to Original Date of June 1st, 1987 with Current Issue Dates of January 15, 2007 and Original Date of May 2008 with Current Issue Date of May 30, 2008.

Interview with the infection control lead and review of the current policy in use confirmed that the policy did not require time frames for screening for tuberculosis on admission and that the program was not being evaluated and updated at least annually.

B) Review of the current policies in use and interview with the Skin and Wound lead confirmed that the policies did not direct the registered staff regarding: weekly wound assessments; referral to physiotherapy as required; assessment and documentation of pain interventions; and strategies to promote healing and prevent infections, which are all required under the LTCHA. (147)

Dietary examples:

A) Different policies for the same topics were in the policy binder (e.g. hydration, supplements, weights, nutrition assessment) and they were not consistent with each other in direction for staff.

B) Nutrition policies available did not identify the requirement of the Registered Dietitian (RD) to complete the admission nutrition assessment and whenever there was a significant change in status, which is required under the LTCHA.

B) The "diet change policy" did not reference the Dietitian's role in diet changes, only the Nutrition Manager (NM).

C) The "Changes in Weight" policy did not reflect the requirement to assess significant weight changes of 5% in one month, 7.5% in 3 months and 10% over 6 months. The policy required assessment of only a 5 pound (lb) change in 1 month or a 10 lb change in 3 months. This practice would miss many of the significant changes in small stature residents and over trigger for larger residents and did not address significant changes over a 6 month period. The "Weight" policy referenced only a 5% change in one month or 10% over 3-6 months and did not require the RD to assess significant weight changes. These policies were not consistent with requirements under the Act.

D) the "Nutritional Documentation" policy did not reference the RD's role in nutritional assessments, only the NM.

E) The "change in hydration" policy indicated that a referral to the RD would occur for all residents taking less than 2000ml/day, initiate a separate "intake" form for the individual, check at least every two hours as to the intake status, document on nurses notes every shift, however, this was not consistent with the



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Hydration Assessment & Management policy.

F) The policy "Resource Instant Protein Powder", created in 1993 and reviewed (no changes) in 2005, 2008, and 2012, did not provide direction to staff related to how to record or monitor the intake of the intervention and the policy was approved by the "Nursing Director". There is no evidence that a Registered Dietitian approved this policy. The policy reflected a protein requirement factor that would be inappropriate for most residents with skin integrity issues.

G) Dietary Aide and Cook job descriptions, created 1999, reviewed 2005, did not include the educational requirements identified in the regulations. (107)

H) The Tyndall employee phone list was not revised. Eleven of 20 staff on the list were not currently working at the home, including the Nutrition Manager. (147)

2. [O.Reg. 79/10, s. 8(1)(b)] Previously issued March 14, 2011, September 22, 23, 2011

The policy and procedure for Responsive Behaviours, last reviewed December 2011, was not complied with for resident #8578 related to monitoring the resident's responsive behaviours. The policy defined the resident's behaviour as a responsive behaviour. Further it identified Dementia Observation Screening (DOS) charting was to be completed to track specific behaviours and time to assist staff with evaluating preventative strategies which may be effective in minimizing and/or eliminating the behaviour. The physician progress notes identified the resident presented with responsive behaviours and was commenced on medication. There was no documentation of the resident having DOS monitoring completed at any time from the initial identification of the responsive behaviour until the period of inspection. (147)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2013



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Order # / Ordre no : 004	Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)
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O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

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

Order / Ordre :



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The licensee shall prepare, submit, and implement a plan that ensures that the plan of care for residents, including residents #1007 and 1006, is based on an interdisciplinary assessment of mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. The plan is to be submitted by July 5, 2013 to Long-Term Care Homes Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :



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1. [O.Reg. 79/10, s. 26(3)5]

Residents' plans of care were not based on an interdisciplinary assessment of mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

A) The responsive behaviour plan of care for resident #1007 was not based on an interdisciplinary assessment of the resident. Interview with staff and documentation in the clinical health records indicated that the resident became agitated and as a result, exhibited certain behaviours. The resident was started on a medication for these behaviours. There was no evidence that an interdisciplinary assessment related to the behaviours had been conducted.

Triggers and variations in functioning at different times of the day had not been identified. The plan of care had not been developed and implemented to manage the responsive behaviours. (147)

B) An interdisciplinary assessment was not completed for resident #1006, related to responsive behaviours and physical aggression, including potential behavioural triggers. The resident's progress notes identified five incidents of physical aggression towards other residents and staff in 2012 and three incidents in 2013. The staff confirmed the incidents did occur and an outside agency was called into the home on each occasion. The resident's RAPS, completed over a five month period, did not identify resident incidents of physical aggression. The RAP for behaviours was not completed in 2013, although the Multidisciplinary Review of Resident's Assessments, prior to MDS coding, identified the resident had episodes of physical aggression in the past quarter. An interdisciplinary assessment of the resident's risk of physical aggression was not completed.

C) The plan of care for resident #1006 did not identify potential behavioural triggers for physical aggression towards others. The resident's progress notes identified the resident was involved in physical aggression towards other residents resulting in an outside agency being called to the home five times in 2012 and three times in 2013. Staff were able to identify triggers indicating the resident may become physically aggressive, however, the resident's current plan of care did not include the identified triggers for physical aggression (141) (147)

This order must be complied with by /

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Order # / **Order Type /**
Ordre no : 005 **Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures that:

- a) a clear policy related to weight changes is in place and that policy is consistent with LTCHA requirements
- b) residents are weighed at minimum monthly and when there are significant changes, those changes are verified by a re-weigh
- c) residents with significant weight changes are assessed by the multidisciplinary staff, including the Registered Dietitian
- d) action is taken to address the weight change and outcomes are evaluated for effectiveness in relation to specified goals related to weight changes
- e) education for staff related to the home's policy on weight changes

The plan is to be submitted by July 5, 2013 to Long-Term Care Homes Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O.Reg. 79/10, s. 69.1]

A) Resident #8607 was not re-assessed after a 9.7% significant weight loss over one month. Progress notes indicated the resident: was eating poorly on numerous days over two months; had an area of skin breakdown; ongoing weight loss in addition to the significant weight loss noted over one month (18.6% loss in 6 months); and the Power of Attorney (POA) requested a



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nutritional assessment by the Dietitian for concerns about weight loss and poor appetite. The Dietitian reviewed the resident after the significant weight loss and clarified the resident's diet order, however, there was no re-assessment of the resident in relation to intake and weight loss, and interventions that had been implemented two months prior were not evaluated for effectiveness at that time. The resident was not assessed by the Dietitian in relation to the significant weight loss until the regularly scheduled quarterly review the next month. At the quarterly review the Dietitian used an incorrect weight for the assessment. Interventions were revised at the quarterly review, however, the supplement initiated provided 90kcal less than the previous intervention without a documented explanation for the reduction in calories or a documented assessment of the resident's requirements in relation to current intake. B) A "weight warning" notification was triggered for resident #8607, however, action was not taken related to the weight loss and outcomes were not evaluated in relation to the goal for weight maintenance within their goal weight range noted at the quarterly review. The resident's weight was noted to be below their goal weight range with no change to the nutritional interventions identified on the resident's plan of care. (107)

2. [O.Reg. 79/10, s. 69.2]

The licensee did not ensure that action was taken and outcomes were evaluated for resident #2144 after further significant weight loss over a three month period. Interventions to prevent further weight loss were initiated previously, however, action was not taken and outcomes were not evaluated after the continued significant weight loss. The resident had a 13.6% significant weight loss over three months, however, the plan was to continue with the current interventions. The Dietitian reduced the resident's goal weight range by 9kg the first month, to a further reduction of six kg the next month and stated that the current interventions were effective. The resident had a goal for the prevention of further weight loss, however, when further weight loss occurred strategies were not revised. The resident was noted to be consuming mainly liquids and often refusing solid foods (as per progress notes and nursing staff interview). The resident continued to lose weight over the three months and interview with the Registered Dietitian confirmed that further action was not taken to address the three month weight loss. (107)

3. [O.Reg. 79/10, s. 69.3]

The licensee did not ensure that action was taken and outcomes were evaluated



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for resident #7804 after a significant 11% weight loss over 6 months. The resident had a goal for the prevention of further weight loss and weight maintenance within their goal weight range, however, the resident continued to lose weight below the goal weight range over a five month period, with only 1 change to nutritional interventions. The plan was to continue with the current plan and the resident's goal weight range was reduced. Nutritional interventions were not evaluated for effectiveness in relation to the goal for the prevention of further weight loss. At the nutritional assessment, the Dietitian used the previous month's weight, despite the current month's weight/re-weight being available which indicated a significant weight loss. (107)

This order must be complied with by /

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Order # /
Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Order / Ordre :

The licensee must ensure that all hazardous substances at the home are kept inaccessible to residents at all times, including chemicals located in janitor's rooms, tub/shower rooms, dining areas.

Grounds / Motifs :

1. Hazardous substances were not kept inaccessible to residents at all times. Disinfectant products, which contain ingredients that are harmful when ingested, were found accessible to residents on numerous occasions throughout the inspection period by all inspectors.

* A spray bottle of disinfectant (Virox) was left in a resident's bathroom on April 2, 2013. A staff member was informed immediately.

* A spray bottle of Virox was found in an unlocked cabinet in the dining room on April 2, 10, 2013 after the noon time meal.

* A door to the furnace room located in the corridor on the main floor was found to be unlocked on April 2, 2013 at 1018 hours. Inside the room was an unlocked housekeeping cart with several cleaning solutions and a bottle of disinfectant inside of the cart. A door was also left wide open to a chemical storage room. The inspector locked the room upon exit. At 1148 hours, the door handle to the furnace room had a key in it and at 1233 hours, the door was found unlocked again. The door was locked by the inspector at 1233 hours.

* At 1011 hours on April 5, 2013, the door to the furnace room was found unlocked, with an unlocked housekeeping cart inside. The cart contained



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disinfectants. The room was locked upon exit by the inspector. The door was found unlocked again at 1147 hours.

* On April 19, 2013, at 1209 hours the tub and shower room on a home area was propped wide open with the key left in the door. A bottle of Virox was accessible on the counter behind the toilet.

* April 19, 2013 at 1219 hours the tub and shower room on a different home area was found unlocked and a bottle of Virox was accessible on the counter behind the toilet.

* On March 22 1232 hours and April 12 1143 hours, the door to a tub room was found unlocked with 1-2 bottles of Virox accessible. The door was locked immediately and staff informed.

* On March 25 at 1014 hours, April 2 at 1030 hours, and April 11 at 1320 hours, a janitor's closet was found unlocked and accessible with multiple bottles of cleaning solutions and disinfectant accessible. Staff were notified and the door was locked by the inspector.

* On March 25, 2013 at 1500 hours, a janitor's closet was found unlocked and accessible with multiple bottles of cleaning solutions and disinfectant accessible. On March 26, 2013 at 1009 hours, the janitor's closet was again found unlocked and accessible and the shower/tub room was also found unlocked and unattended with hazardous chemicals accessible on the back of the toilet.

* On March 21 at 945 hours, during a tour of the home, a tub room and janitor's closet were found unlocked and accessible to residents. The tub room contained a bottle of Virox and the janitor's room had a housekeeping cart with multiple bottles of disinfectant and cleaning solutions. On a different floor, the janitor's room was also found unlocked and unattended with cleaning fluids and disinfectants in unlocked housekeeping cart.

Management was informed of the inspector's concerns on numerous occasions with continued non-compliance with keeping chemicals inaccessible to residents.

(120)(147)(107)(141) (120)



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Vous devez vous conformer à cet ordre d'ici le : Jun 22, 2013



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Order # /
Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 109. Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,

(a) use of physical devices;

O. Reg. 79/10, s. 109.

Order / Ordre :

The licensee shall develop, implement, and educate staff on a policy that deals with the use of physical devices, and that policy shall include all of the required elements listed under the Act and Regulations.

Grounds / Motifs :

1. The home's policy for Restraints, last reviewed April 2008, did not include procedures for the use of Personal Assistance Services Devices (PASD) and bed rails.

A) The Restraint policy defined PASDs. A policy was not in place to direct staff in the requirements for PASDs including assessment, inclusion in the individual's plan of care, approval and consent. Multiple residents on all home areas were identified as using two half and quarter bed rails when in bed. The DOC confirmed that PASDs were not assessed prior to implementation and there was no policy related to PASDs specifically.

B) The Restraint policy stated bed rails for the purpose of this document were not classified as a restraint. The policy did not include requirements for assessment of bed rails to identify if they were a restraint. Two residents were identified in the home as requiring full length bed rails when in bed. The DOC stated that the use of two full bed rails were considered restraints. (141)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2013



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Order # /
Ordre no : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

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The licensee must prepare, submit and implement a plan that outlines how the home will ensure that all mattresses in the home are kept in good repair. The plan should include:

- a) timeframe for replacement of all mattresses in poor condition
- b) a process to identify mattresses in poor condition
- c) a communication system to ensure that the identified mattresses can be addressed
- d) a system for replacement of mattresses that are not in good condition
- e) quality management activities to evaluate the effectiveness of the processes/systems implemented

The plan is to be submitted by July 5, 2013 to Long-Term Care Homes Inspector Michelle Warrener, at: Michelle.Warrener@ontario.ca.

Grounds / Motifs :



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1. Procedures were not developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair, excluding the residents' personal aids or equipment.

Review of all the resident mattresses for two floors, and interview with staff on each floor, indicated that procedures were not implemented to ensure that all the mattresses in the home were kept in good repair. Fourteen of the mattresses identified had broken mattress cover zippers and/or tears/significant wear in the mattress covers exposing the mattress foam. There were approximately three to seven centimeter (cm) divots in the middle of the mattresses and the protective surfaces on top of the mattresses were worn, exposing rips in the fabric which posed a risk for contamination and infection to the residents. Three examples from the 14 mattresses noted to be in poor repair:

A) Resident #8448's mattress was found to have severe sagging in the middle with extensive wear of the water proof cover exposing porous material underneath. The resident was not able to articulate comfort of mattress due to level of cognitive impairment. Resident currently had multiple areas of skin breakdown.

B) Resident #1011's mattress had a 6 cm divot in the centre. The resident had a significant area of skin breakdown.

C) Resident #1009's mattress had the surface worn away, with white worn patches covering the surface, and a 5 cm divot in the middle of the mattress. The resident had a significant area of skin breakdown. (147)

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Order # /
Ordre no : 009

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

- (a) a goal in the plan is met;
- (b) the resident's care needs change or care set out in the plan is no longer necessary; or
- (c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures that residents are re-assessed and their plans of care reviewed and revised when their care needs changed or care in the plan was no longer necessary in relation to:

- a) changes in recreation participation
- b) bed rails
- c) continence
- d) pain

This includes residents #4592, 1004, 2144, 8593.

The plan is to be submitted by July 5, 2013 to Long-Term Care Homes Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(b)] Previously issued September 23, 2011 as a VPC

Residents were not reassessed and their plans of care reviewed and revised when the residents' care needs changed or care set out in the plan was no longer necessary.

A) The plan of care for resident #4592 was not revised when their care needs changed in relation to activation/recreation. The resident had a significant change in status in 2012, which resulted in some changes to the resident's participation levels. The recreation plan of care was not revised in relation to the



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change in condition. Staff stated the resident was participating more passively than they used to with a change from moderate participation to low participation. The resident's Index of Social Engagement (ISE) score decreased from two, to one two months later, and zero, three months after that. Review of the resident's recreation participation records also reflected a decline in participation without revision to the resident's plan of care. The resident participated 16 times one month, 11 times the next month, 11 times the subsequent month, 8 times the next month and 4 times the following month. Coding and Resident Assessment Protocols (RAPS) for the RAI-MDS quarterly review did not reflect a change in participation levels or in the type of activities the resident was participating in and interventions were not revised in relation to the changes noted by staff. The resident had a goal for weekly religious programming. The resident was participating in weekly services the first two months reviewed, however, participation dropped to once a month in subsequent months without an evaluation of the decline. (107)

B) Resident #1005 was not reassessed quarterly for the use of two full length bed rails as a restraint. The resident was observed in bed with the bed rails raised. The MDS coding identified the use of two full bed rails daily. The RAP for restraints was not triggered and not completed. (141)

C) Resident #1004 was not reassessed and the plan of care reviewed quarterly for the use of two full length bed rails as a restraint. The resident was observed in bed with the bed rails raised. The Minimal Data Set (MDS) coding identified the use of two full bed rails daily. The RAP for restraints was not triggered and not completed. The resident's current plan of care was not reviewed by staff and the bed rails were not identified as a restraint. (141)

D) Resident #2144 was not re-assessed in relation to changes that occurred in the resident's recreation participation levels at their quarterly review. The resident's participation records reflected that participation improved over a two month period, and staff confirmed that the resident was participating more frequently. An assessment of the change did not occur and the coding and RAP summary did not reflect a change in the resident's participation levels. (107)

E) The plan of care for resident #8593 was not reviewed and revised when the resident's care needs changed in relation to continence. The resident's room had a strong odour of urine on two occasions during the inspection. The resident's quarterly assessment (RAP) documented that the resident was: occasionally incontinent of bladder; at risk for infection and falls and those would be addressed in the care plan; and that the floor should be clean and dry due to urine dribbling. Staff confirmed the resident was incontinent at times and did



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dribble urine. Staff stated the resident remained independent in toileting but sometimes missed the toilet causing urine to splash on the bathroom floor. Staff also confirmed the odour of urine in the room was from resident #8593. The resident's current plan of care did not address that the resident dribbled or missed the toilet when voiding and there were no strategies in place to address the dribbling of urine or urine on the floor, including monitoring for keeping the floor clean and dry as identified in the assessment.(141)

F) Resident #8593 was not reassessed and the plan of care reviewed and revised when care needs changed in relation to pain. Documentation in the resident's progress notes and Medication Administration Records (MARs) identified the resident as having pain over a 10 day period for which they received pain medication 14 times. Documentation in the resident's MDS coding identified the resident had mild pain, less than daily, associated with headache for which they received pain medication. The resident did not have a completed RAP for pain at this time. The resident's plan of care identified the resident had pain, however, did not include all sources of pain. The resident stated they suffered pain. (141) (107)

This order must be complied with by /

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Order # /
Ordre no : 010 **Order Type /**
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Order / Ordre :

The licensee shall develop and implement a quality improvement system that includes action plans to address areas identified with deficiencies.

Grounds / Motifs :

1. The home had developed a quality improvement system, however, they had not included action plans to address the areas with deficiencies and not all programs had been included in the quality monitoring system. Staff confirmed that action plans were not currently in place to improve the quality of the accommodation, care, services, programs and goods provided to residents. Numerous areas of non-compliance were identified during this inspection. Staff were unaware of some of the identified concerns and were unable to provide evidence of action taken to improve the areas of concern identified through their system. (107)

This order must be complied with by /

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Order # / Ordre no : 011	Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)
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Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

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

Order / Ordre :

The licensee shall prepare and submit a plan that identifies the following by July 5, 2013;

1. How the home intends to mitigate risks to residents who currently use a bed rail and sleep in a bed that was identified to fail any entrapment zone.
2. Who will conduct the assessments.
3. How the home intends to monitor bed systems in the long term to ensure they remain compliant with bed safety guidelines.

The plan shall be implemented within 6 months of the date of this Order.

The written plan shall be submitted by email to Bernadette.Susnik@ontario.ca or by mail to Bernadette Susnik, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care Improvement and Compliance Branch, 119 King St. W., 11th floor, Hamilton, ON L8P 4Y7.

Grounds / Motifs :

1. Steps have not been taken to prevent resident entrapment, taking into consideration all potential zones of entrapment where bed rails are used.



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The home commissioned an external contractor to complete a bed entrapment zone audit of all the resident bed systems in October and November 2012. The contractor used the Health Canada Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards", (2008) as a guide to determine which beds passed or failed the specified parameters. The results of the audit concluded that over 60% of the beds failed one or more zones of entrapment which could potentially cause injury to the resident. Since that time, the management of the home have not instituted any measures to minimize or mitigate potential risk to the residents.

During a tour of the home, some gaps between head boards and mattresses and bed rails and mattresses were observed. These are areas that failed bed safety parameters during the audit. The home has a mix of bed models and mattresses of different ages. The older the mattresses, the more likely they will fail one of the entrapment zone parameters. According to the home administrator, many of the mattresses are older than seven years, which would decrease their ability to resist compression. Another parameter where beds are likely to fail is with the type and design of the bed rail. Some beds are furnished with quarter length assist bed rails and others with full length rails. Bed mattresses were noted to be either too long or too short for the bed frames. Mattresses that are too short create excessive gaps at the head or foot of the bed (entrapment zone 7). Mattresses that are too long can bunch in the center and may not lie flat. A number of bed frames had missing mattress keepers to keep the mattresses from sliding side to side. When beds without mattress keepers were tested, the mattresses easily slid off the frame of the bed.

Therapeutic surfaces were also noted on bed frames. These surfaces have inherent entrapment risks based on their design (soft edges, height and compressible nature). One therapeutic surface was not attached to the deck of the bed as required by the manufacturer.

At the time of this inspection, many of the failed beds continue to be used by residents who use bed rails. Since the audit, some new mattresses have been purchased, however the management did not identify or document which bed frames they were applied to. The beds that received a new mattress also did not receive a post entrapment zone assessment to determine if the new mattresses were adequate for the specific bed frame. (120)



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Vous devez vous conformer à cet ordre d'ici le : Dec 22, 2013



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Order # / **Order Type /**
Ordre no : 012 **Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that outlines how the home will ensure that a system is in place for documenting and evaluating nutritional interventions provided to residents, including great shakes and protein powder.

The plan is to be submitted by July 5, 2013 to Long-Term Care Homes Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O. Reg. 79/10, s. 30(2)] Previously issued March 14, 2011
Actions taken with respect to residents #2144, #8607, and #8610, under the nutrition and hydration program, including assessments, reassessments, interventions and the resident's response to interventions were not documented.
A) Action taken with respect to resident #2144, including the administration of protein powder and nutritional supplement interventions, for the treatment of impaired skin integrity/wounds, was not documented.
i) Resident #2144 required protein powder at multiple meals, however, documentation did not include a record of the administration of the protein powder or the resident's consumption of the protein powder. The Dietitian and Registered Nursing staff confirmed that an evaluation of the effectiveness of the protein powder could not be completed with the available information. The resident's wounds were not healing. Registered Nursing staff confirmed that a system was not in place to record or evaluate the consumption of protein powder being provided by dietary staff.
ii) The resident required a nutritional supplement for the prevention of weight loss and for skin integrity concerns, however, documentation did not include the



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consumption of the supplement and interventions could not be evaluated for effectiveness. The resident had ongoing weight loss and skin integrity concerns. (107)

iii) The resident was observed by the inspector in the dining room and protein powder was placed in their soup by the dietary aide. The resident consumed half of their soup. Nursing staff assisting the resident with feeding confirmed the resident only consumed half of the soup. The resident had multiple areas of poor skin integrity. There was no documentation identified to monitor the residents intake of the protein powder and soup. (141)

B) Action taken with respect to resident #8607, including the administration of protein powder for the treatment of impaired skin integrity/wounds, was not documented. Resident #8607 required protein powder at meals, however, documentation did not include a record of the administration of the protein powder or the resident's consumption of the protein powder. The Dietitian and Registered Nursing staff confirmed that an evaluation of the effectiveness of the protein powder could not be completed with the available information. Registered Nursing staff confirmed that a system was not in place to record or evaluate the consumption of protein powder being provided by dietary staff. (107)

C) Action taken with respect to resident #8610, including the administration of protein powder for the treatment of impaired skin integrity/wounds, was not documented. Resident #8610 required protein powder at multiple meals, however, documentation did not include a record of the administration of the protein powder or the resident's consumption of the protein powder. The Dietitian and Registered Nursing staff confirmed that an evaluation of the effectiveness of the protein powder could not be completed with the available information. The resident's wound had worsened and was not healing. Registered Nursing staff confirmed that a system was not in place to record or evaluate the consumption of protein powder being provided by dietary staff. (107)

D) Resident #4592 was observed in the dining room and protein powder was placed in their soup by the dietary aide. The resident refused the soup and the refusal of soup was confirmed by the nursing staff assisting the resident. The resident had multiple significant pressure ulcers. Documentation did not include the resident's refusal of the protein powder and soup and the resident's response to the intervention of protein powder could not be evaluated by the Dietitian without documentation to support the refusal. (141)

E) Resident #1009 was observed in the dining room and protein powder was



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placed in their soup by the dietary aide. The resident consumed the soup with the protein powder, however, documentation did not include a record of the resident's consumption of the intervention. The resident had multiple areas of poor skin integrity. There was no documentation identified to monitor the residents intake of the protein powder. (141) (107)

2. [O. Reg. 79/10, s. 30(2)]

Resident #2144 did not have all interventions and responses to interventions documented related to catheter care.

A) Urine output by catheter was not consistently documented in the progress notes or Point of Care (POC) at the end of each shift. The resident's written plan of care included specific directions for staff on monitoring urine output. The DOC confirmed that documentation of urinary output should be recorded at the end of each shift in the POC and progress notes.

B) Documentation in the progress notes at the time of catheter change did not include all actions taken. The home's policy and procedure "Urinary Catheterization", last reviewed April 2008, stated when changing an indwelling catheter document in progress notes and care plan the type, size and inflation of catheter; appearance and amount of urine obtained; change date on care plan, type and size of catheter and amount inflated; residents response to procedure. Documentation in the progress notes at the time of catheter change did not include the type, size and inflation of catheter; appearance and amount of urine obtained; change date on care plan, type and sized of catheter and amount inflated; residents response to procedure. (107)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2013



**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
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Order # / Ordre no : 013	Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)
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Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,

(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;

(b) the identification of any risks related to nutrition care and dietary services and hydration;

(c) the implementation of interventions to mitigate and manage those risks;

(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

(e) a weight monitoring system to measure and record with respect to each resident,

(i) weight on admission and monthly thereafter, and

(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that outlines how the home will ensure that a system is in place to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

The plan shall include

a) a system to monitor the afternoon snack pass for residents and education provided for staff on the monitoring process.

b) a system to identify and take action for residents with insufficient food and fluid intake

The plan is to be submitted by July 5, 2013 to Long-Term Care Homes Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :



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1. [O.Reg. 79/10, s. 68(2)(d)]

A system to monitor and evaluate the food intake of residents who were at nutrition risk was not in place.

A) Resident #8610, who was at high nutrition risk, did not have their food intake consistently monitored. There were 58 missing entries for the afternoon snack consumption on the Point of Care (POC) nutrition documentation over a two month period. Staff confirmed that the afternoon snack pass was not always recorded for residents due to computer system set up concerns.

B) A system to monitor the food and fluid intake was not consistently in place for resident #7804, who was identified with nutritional risks. Documentation on the POC nutrition monitoring records identified nine missing snacks entries and 14 missing meals over a 1.5 month period. The resident had a significant weight loss of 10.9% over 6 months.

C) A system to monitor and evaluate resident #2144's food and fluid intake was not in place. The resident was identified as high nutrition risk, however, consumption of meals and snacks was not consistently documented in the resident's clinical record. There were 76 missing entries for snacks over a two month period (mainly afternoon and evening snacks) and 11 missing records for the supper meal. The resident's food and fluid intake could not be effectively evaluated with amount of missing data. (107)

This order must be complied with by /

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Order # /
Ordre no : 014

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

Pursuant to / Aux termes de :

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

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall ensure that proper techniques are used to assist resident with eating, including safe positioning of residents who require assistance. This includes residents #5106, 1025, 1023/1024.



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Grounds / Motifs :

1. [O.Reg. 79/10, s. 73(1)10]

Proper techniques, including safe positioning, were not used to assist residents with eating.

A) During the afternoon snack pass on April 16, 2013, resident #1023/#1024 was being fed by staff while in a reclined chair and not in an upright position. Staff feeding the resident did not reposition the resident prior to feeding and the resident yelled, "Wait, Wait". The resident was slightly repositioned after that, however, they remained in a reclined position and staff proceeded to feed the resident again.

B) Proper techniques were not used to assist resident #5106 with eating at the lunch meal March 21, 2013. The resident was reclined in their wheelchair and had their chin pointed towards the ceiling (not tucked for safe swallowing) while being fed by staff. The resident was being fed by a staff member and was noted to be coughing while being fed. The resident's plan of care stated dysphagia with risk for coughing/choking/aspiration and to position the resident in an upright position. The inspector asked for the resident to be repositioned.

C) Proper techniques were not used to assist resident #1025 at the supper meal April 16, 2013. Staff were observed standing to feed the resident and were not at eye level when assisting the resident. (107)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Jun 28, 2013



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Order # /

Ordre no : 015

Order Type /

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

Pursuant to / Aux termes de :

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

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that outlines how the home will ensure that all the required training will be provided to all staff who provide direct care to residents.

The plan is to be submitted by July 5, 2013 to Long-Term Care Homes Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :



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1. For the purposes of paragraph 6 of subsection 76 (7) of the Act, the other areas in which training was not provided to all staff who provide direct care to residents included:

- A) Falls Prevention and Management
- B) Skin and wound care
- C) Continence care and bowel management
- D) Training in the application, use and potential dangers of physical devices for staff who apply physical devices or who monitor residents restrained by physical devices
- E) Training in the application, use and potential dangers of the PASDs, for staff who apply PASDs or monitor residents with PASDs.

Review of the home's training schedule for 2012/2013 and interview with the DOC and registered staff confirmed the required training was not provided to staff. (147)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2013



Ministry of Health and
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Order # / Ordre no : 016	Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)
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Pursuant to / Aux termes de :

O.Reg 79/10, s. 129. (1) Every licensee of a long-term care home shall ensure that,

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

Order / Ordre :

The licensee shall ensure that medication carts are secure and locked and that drugs are stored in a manner that complies with manufacturer's instructions.

Grounds / Motifs :

1. [O.Reg. 79/10, s. 129(1)(a)(ii)]

Drugs were not consistently stored in a medication cart that was secure and locked.

A) On April 16, 2013 at 1530 hours two medication carts were left unlocked and unattended by staff. The carts were in-front of the nursing station facing the elevators and staff left the carts unattended while they went to the nursing room to get supplies. Staff interview confirmed that the staff were aware the carts were to be locked when unattended. (107)

B) On April 16, 2013 at 1620 hours a medication cart was left unlocked and unattended while the RPN was providing care in a resident's room. The medication cart was left in the hallway and was not visible from the room that the care was being provided. When the staff returned to the cart they asked the inspector, "Do I really have to lock the cart every time?". (107)



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C) On April 10, 2013, during observation of morning medication administration, two medication carts were stationed outside the nursing station with the cart drawers facing the elevator. Two RPNs were administering medication from the carts. One RPN went down in the elevator and the second RPN went behind the nursing station, where the medication carts were out of visual view, to speak with the inspector. Approximately five minutes later the inspector walked out of the nursing station and both medication carts were unlocked and had been unattended. This observation was identified with the second RPN, who confirmed the carts should of been locked. (141)

D) On April 22, 2013 at 1536 hours an inspector observed a RPN administering medication from the medication cart situated outside a nursing station. On two occasions the nurse administered medication to residents in the lounge area which was out of visual view of the cart and the cart was left unlocked. On one occasion the nurse administered medication to a resident in the hallway out of visual view of the cart and the cart was left unlocked. (141) (141)

2. [O.Reg. 79/10, s. 129(1)(a)(iv)]

On April 10, 2013, during inspection of two medications carts, residents #5581, #1010 and #0812 had prescribed, opened eye drops stored in the medication cart without the date documented when the drops were initially opened. The home's policy Auto-Refill (Eye Preparation) stated the date the eye preparation is opened should be recorded in the appropriate place on the label of the container in order to avoid confusion and as part of risk management. A blank label was attached to the containers for provision of the information. (141)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Jun 28, 2013



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Order # /
Ordre no : 017 **Order Type /**
Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will ensure that clear direction is provided to staff and others providing direct care to residents in relation to oral care, specialized mattresses, bed rails, one to one programming, supplements, and level of assistance required for eating.

The plan is to be submitted by July 5, 2013, to Long-Term Care Homes Inspector, Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(c)]
The plan of care for resident #2144 did not set out clear directions for staff and others who provided direct care to the resident.
A) Clear direction was not provided for the cleaning of teeth. The resident was observed on March 26, 2013 with odourous breath, and on April 12, 2013 at 1045 hours with build up of food debris between their teeth. The resident's RAP in 2012 stated debris was present in their mouth after meals. Oral hygiene was not recorded as being completed on two of eight shifts over a four day period. The Home's policy and procedure Oral Hygiene (#0-2012-01) last revised February 3, 2013, stated "All residents will received or be provided with oral hygiene at a minimum of twice daily (morning and night). This oral hygiene will be individualized to meet the preferences and the abilities of each resident based on an assessment". The written plan of care, kardex, and Resident Assessment Protocol (RAP) did not identify the frequency of oral care to be



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provided for the resident to maintain appropriate oral hygiene. (141)

B) The plan did not provide clear direction related to protein powder served at the breakfast meal. The resident was changed from hot cereal to cold cereal and the plan directed staff to put protein powder in the cereal at breakfast. During interview April 15, 2013, the Dietitian stated that staff were to mix the protein powder into the milk and then pour the milk onto the cereal. Staff who add the protein powder at the breakfast meal stated they put the powder on top of the cereal and then add the milk. The dietary aide stated that the protein powder did not mix well with the cold cereal and did not dissolve well. Direction was not provided to staff in the home's policy or in the resident's plan of care on how to administer the protein powder in the cold cereal. (107)

C) The written plan of care did not set out clear directions related to the level of pressure to be used for a specialized mattress the resident required to promote skin integrity. The mattress had the ability to adjust the level of firmness from low to high. The plan of care did not identify the required level of firmness to ensure the resident's comfort needs, skin integrity, and pain reduction were maintained. Review of the plan of care and interview with the Director of Care (DOC) confirmed that clear direction to staff, related to the need for and use of the specialized mattress, was not provided. (147)

D) The plan of care did not provide clear direction related to recreation and social activities. The resident required one to one programming to reduce the risk of isolation, however, direction as to the type or frequency of one to one programming was not provided. Activation participation records reflected one 1:1 program was provided one month, two the next month, three in the next two months, and two the following month. The resident's group participation was low (two programs, including 1:1 for one month, five the next month, 11 in the following month, seven the next month and six the following month), however, the resident was identified as low risk on the 1:1 list. Direction was not provided as to the frequency of one to one programming to meet the goal of preventing social isolation. During interview, staff confirmed direction was not provided as to the frequency of one to one programming and that they provide one to one programs when they can. (107)

The plan of care for resident #4592 did not set out clear directions for staff and others who provided direct care to the resident.

A) The plan of care did not provide clear direction related to the use of bed rails when in bed. The resident was observed to be in bed with one quarter bed rail



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raised on two occasions during the review. Staff stated they put the side rail up for safety. The resident's plan of care identified the resident was at risk for falls and rest needs but did not include the use of a bed rail as a strategy. (141)

B) The plan of care did not provide clear direction related to activation and one to one programming. The plan of care directed staff to provide one to one interventions when participation in group programs decreased. The resident had a decrease in group programming, however, the plan did not direct staff as to the frequency and type of one to one programming to provide to the resident. (107)

C) The Nutrition Risk focused section of the resident's plan of care directed staff to refer to the "Eating" focus on the plan of care, however, an "Eating" focus was not included in the plan of care. Direction was not provided to staff related to the type or quantity of assistance required for eating during meals and snacks. (107)

The plan of care for resident #8509 did not set out clear directions for staff and others who provided direct care to the resident.

A) The plan of care did not provide clear direction to staff related to the use of bed rails. The resident was observed during the inspection to have one half bed rail in place when in bed. Staff confirmed the resident used one half bed rail for turning in bed. Strategies in the resident's plan of care for falls included direction to encourage the resident to use bed rails. The plan did not specify the number or length of bed rails to be used. (141)

The plan of care for resident #1004 did not set out clear directions for staff and others who provided direct care to the resident.

A) The plan of care did not set out clear direction to staff for the use of two full length bed rails as a restraint. The current plan of care for risk of falls identified the use of bed rails for safety when in bed, however, did not specify the equipment as a restraint and did not include specific strategies required when a restraint was in place.(141)

The plan of care for resident #8610 did not provide clear direction for staff and others who provided direct care to the resident.

A) The "Eating" focus of the resident's plan of care directed staff to provide a nutritional supplement, however, the "Nutrition Status" focus of the plan of care



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directed staff to provide a different nutritional supplement. The different sections of the plan of care were not consistent in relation to the type of supplement required for the resident. (107) (147)

This order must be complied with by /

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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



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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.



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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, 11^e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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



**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*

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la
conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 20th day of June, 2013

Signature of Inspector /
Signature de l'inspecteur : *M. Warrener, RD*

Name of Inspector /
Nom de l'inspecteur : MICHELLE WARRENER

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