Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25, 26, 28, Jul 4, 5, 6, Aug 21, 22, 23, 24, Sep 20, 21, Oct 3, 11, 15, 2012	2012_053122_0014	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

LAKEHEAD MANOR
135 SOUTH VICKERS STREET, THUNDER BAY, ON, P7E-1J2

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

ROSE-MARIE FARWELL (122), LAUREN TENHUNEN (196), MARGOT BURNS-PROUTY (106), MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Environmental Services Manager, Food Services Manager, Registered Dietician, RAI Coordinator, Registered Staff, Personal Support Workers, Housekeepers, Dietary Aides, residents of the home, family members

During the course of the inspection, the inspector(s) observed the provision of care and services to residents of the home, reviewed various policies and procedures and resident health care records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following subsections:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

s. 71. (7) The licensee shall ensure that food and beverages that are appropriate for the residents' diets are accessible to staff and available to residents on a 24-hour basis. O. Reg. 79/10, s. 71 (7).

Findings/Faits saillants :

1. Staff member 1004 was interviewed by the Inspector on June 13, 2012, and reported that each unit no longer has a stocked pantry with puddings,
sandwiches and beverages for residents who are hungry during the night. Staff member 1005 was interviewed by the Inspector on June 20, 2012 and stated "snacks and beverages are not always available 24 hours a day". Staff member 1005 added that the units are no longer stocked with snacks and beverages during the night. The licensee failed to ensure that food and beverages that are appropriate for the residents' diets are accessible to staff and available to residents on a 24-hour basis. [LTCHA 2007, O. Reg. 79/10, s. 71 (7)]

2. Staff member 1006 was interviewed by the Inspector on June 20, 2012 and reported that residents who receive regular and minced diets have access to food, such as, bread and crackers which are kept stocked on the unit at all times. Staff member 1006 reported that there are not always options available for residents who require a puree diet. The licensee failed to ensure that appropriate food and beverages for all residents diets are accessible to staff and available to residents on a 24-hour basis. [LTCHA 2007, O. Reg. 79/10, s. 71 (7)]

3. Inspector observed resident 47440 on June 18, 2012. Inspector observed as the afternoon beverage and snack pass occurred on third floor. Inspector noted that it was completed by several different staff members. Inspector noted that at no time during or after the pass did any staff member enter
resident 47440's room to offer the resident a beverage or snack. The licensee failed to ensure that each resident is offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner and a snack in the afternoon and evening. [LTCHA 2007, O.Reg. 79/10, s.71 (3)]

4. Inspector observed the am snack pass on third floor on June 19, 2012. Inspector noted that the snack cart did not leave the common area in front of the elevators. Inspector noted at no time did any staff members enter
resident 47440's room to offer him a beverage. The licensee failed to ensure that each resident is offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner. [LTCHA 2007, O.Reg. 79/10, s.71 (3)]

5. Inspector observed the afternoon snack pass on third floor on June 19, 2012. Inspector noted that the snack cart did not leave the common area in front of the elevators. Inspector noted that a staff member took a spoonful of puree food into resident 47440's room. Inspector observed as the staff member exited the room seconds later identifying loudly that the resident refused. The inspector noted that the PSW did not bring in any fluids to offer to the resident. The licensee failed to ensure that each resident is offered a minimum of a between meal beverage in the morning and afternoon and a beverage in the evening after dinner. [LTCHA 2007, O.Reg. 79/10, s.71 (3)]

Additional Required Actions:

CO # - 901, 902 were served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following subsections:

s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;
(c) that the local medical officer of health is invited to the meetings;
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

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. (8) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and
(b) a written plan for responding to infectious disease outbreaks. O. Reg. 79/10, s. 229 (8).

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.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
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.
5. There must be a staff immunization program 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 :

On June 19, 2012, Inspector observed a contact precautions sign and infection control cart located outside of a resident room. Inspector reviewed the 24 hr report which did not identify any active infections on the unit as per the home's infection control protocol. Inspector interviewed the staff member who was observed administering medications to the residents on the unit. The staff member, whose name is unknown reported that they were new and orientating to the unit and were unaware of the purpose of the signage. Inspector interviewed staff member 1007 regarding the contact precautions signage located outside of the resident room. The staff member pointed to the resident seated next to them in the wheelchair, in the TV area and stated "we were told the resident doesn't have to stay in their room" and to wear gloves when providing care. Inspector inquired if the resident was infected with MRSA, staff member 1007 nodded. Inspector reviewed the resident's health care record and noted that the resident's urine was infected with Extended Spectrum Beta Lactamase producing bacteria (ESBL). On June 20, 2012, the Inspector interviewed staff member 1008 who confirmed that resident 47401 was infected with ESBL. The staff member stated that they had expressed concern regarding resident 47401 sharing a room with another resident and had inquired if the resident shouldn't be segregated in a private room. Staff member 1008 added that staff were informed resident 47401 did not require a private room, or cohorting because the privacy curtain was barrier enough and that the roommate of resident 47401 was tested for ESBL and results were negative. Staff member 1008 explained that resident 47401 did not physically use the toilet, but the resident's room mate does. Staff member 1008 explained that the contents of resident 47401's catheter bag are emptied into a container and the urine disposed of in the toilet. Both the container and the toilet are to be disinfected and staff were to wear gloves when providing care. The licensee failed to ensure that there was in place an outbreak management system for detecting, managing and controlling infectious diseases outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts. [LTCHA 2007, O. Reg. 79/10, s. 229 (8) a]

2. During an interview on June 21, 2012, the DOC reported that the procedures staff are to follow when caring for resident 47401 are to gown, glove and mask before entering the room of the ESBL positive resident. The DOC also reported that staff should not flush the infected urine down the toilet in the washroom that is shared by her roommate who is not ESBL positive. Staff are to take the urine to the "hopper" to dispose of it. On June 21, 2012, two staff members on the home area reported to the Inspector that they only apply gloves prior to and while providing care to the ESBL positive resident. One staff member was unaware of any other interventions that were to be implemented to prevent the spread of ESBL. The other staff member reported that when draining the resident's catheter bag, they drain it into a can and then empty the can into the resident's toilet. The can and toilet are then disinfected. Both staff members stated that they were unaware of what infection the resident was suffering from and only one of the staff members was aware that the infection was transmitted through urine. Inspector reviewed the health care record of resident 47401 and noted that the resident's plan of care does not include interventions on what precautions staff should implement to prevent the spread of ESBL while caring for resident 47401. [LTCHA 2007, O. Reg. 79/10, s. 229 (8) (a)]

3. Inspector reviewed the health care record of resident 47569 who was admitted to the home on December 19, 2011. Inspector found no documented evidence of TB Screening by 2 Step Mantoux Skin Test.

Inspector reviewed the health care record of resident 47532 who was admitted to the home on August 18, 2011. Inspector found no documented evidence of TB Screening by 2 Step Mantoux Skin Test.

Inspector reviewed the health care record of resident 47550 who was admitted to the home on April 10, 2011.Inspector found no documented evidence of TB Screening by 2 Step Mantoux Skin Test.

The licensee failed to ensure that 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. [LTCHA 2007, O. Reg. 79/10, s. 229 (10)1].

4. On June 21, 2012, the Inspector interviewed the Director of Care (DOC) regarding the home's Infection Prevention and Control Program. The DOC reported that the home does not currently have an Infection Prevention and Control Team. The licensee failed to ensure that here is an interdisciplinary team approach in the co-ordination and implementation of the Infection Prevention and Control program. [LTCHA 2007, O. Reg., s. 229 (2) (a)]

Additional Required Actions:

CO # - 903, 910, 911 were served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care
Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. Inspector reviewed the health care record for resident 47368. Inspector noted that the resident is at high risk for pressure ulcers and unable to reposition independently. Inspector noted the resident sitting in a tilt wheelchair with a lap belt in the common area in front of the elevator on third floor on June 15, 2012. Inspector observed the resident from 09:46h until 12:04h. Inspector noted at no time during this observation was the resident repositioned. The licensee failed to ensure that a resident who is dependent on staff to be repositioned has been repositioned at least every two hours. [LTCHA 2007, O.Reg. 79/10, s.50(2)(d)]

2. Inspector noted that resident 47440 had altered skin integrity. Inspector reviewed the resident’s health care record including weekly skin assessments conducted by registered nursing staff. Inspector noted the documentation indicated the resident’s wound was first noted on January 21, 2012. Inspector noted between January 21, 2012 and June 15, 2012 that a weekly skin assessment by a member of the registered nursing staff was completed for seven weeks of the twenty two week period. The licensee failed to ensure that a resident who is exhibiting altered skin integrity receives an assessment by a member of the registered nursing staff at least weekly.[LTCHA, 2007, O. Reg. 79/10, s.50(2)(b)(iv)]

Additional Required Actions:

CO # - 904, 905 were served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following subsections:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents.
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home’s emergency plans. O. Reg. 79/10, s. 9. (1).

Findings/Faits saillants :

1. June 21, 2012 at 14:40 hrs, Inspector noted the door off the main floor dining room is not kept locked. Inspector was able to open the door and enter into the hallway. Inspector was then able to open a door labelled kitchen and enter into the kitchen. This door was not locked. The licensee failed to ensure doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents. [LTCHA 2007, O.Reg. 79/10, s.9 (1) 2]

2. June 21, 2012 at 14:40 hrs, Inspector noted the door from the main floor dining room is not kept locked. Inspector was able to open the door and enter into the hallway. Inspector was then able to open an unlocked door labelled "fire door" and enter into a small storage area. This Inspector spoke with staff member 1003 from maintenance who identified the door should be locked. The licensee failed to ensure doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents. [LTCHA 2007, O.Reg. 79/10, s.9 (1) 2)]

3. June 19, 2012 at 1507 hrs, Inspector noted the door off the main floor dining room is not kept locked. Inspector was able to open the door and enter into the hallway. Inspector was then able to open a second unlocked door and enter into the stairwell. Inspector noted that no alarm sounded when either of the doors were opened. Inspector noted no door access control system on the door. Inspector spoke with staff member 1021 who confirmed there is no lock on the doors and that there has never been any lock or alarm on the door leading to the stairway. The licensee failed to ensure doors leading to the stairway are kept closed and locked. [LTCHA 2007, O.Reg. 79/10, s.9 (1) 1 (i)]

4. June 19, 2012 at 1507 hrs, Inspector observed the alarmed exterior door at end of laundry/kitchen hallway propped open to the outside. No staff members were observed in the general vicinity of the open door. Inspector contacted the Environmental Services Manager and the door was closed and locked. The licensee failed to ensure doors leading to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to are kept closed and locked. [LTCHA 2007, O.Reg. 79/10, s.9 (1) 1 (i)]

Additional Required Actions:

CO # - 906, 907 were served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

June 15, 2012, Inspector observed the walls in the 3rd floor spa room were heavily gouged, the paint chipped, a 4x4 inch piece of drywall was cut from wall located behind the tub. Grip tape on floor is worn away in most areas. The finish on cabinet located in corner of spa room was grossly peeling and the chip board construction along bottom of cabinet was noted to be rotting. The paint on supply room door located within the 3rd floor spa room was grossly chipped.

June 15, 2012, Inspector observed the flooring located on the north end of the 5th floor hallway was heavily scuffed. The handrails along both sides of the 5th floor corridor were scratched and the paint was worn. The flooring at the entrance to a resident's room was lifting and the flooring located by the 5th floor, south stairwell exit was noted to have a large gouge. The elevator doors located by the 5th floor nursing station were heavily scuffed towards the bottom of the frames.

June 15, 2012, Inspector observed the drywall and baseboards located at the south end of the 6th floor corridor were heavily scuffed. The flooring in most residents' rooms were stained or soiled with unknown substances, Inspector noted the staining was especially prevalent at the juncture of the flooring and drywall in the resident rooms where flooring material was substituted for baseboards. A large piece of flooring was missing and posed a tripping hazard, immediately inside the doorway of 6th floor TV room located beside the Spa. Walls of the public washroom, north side corridor, was chipped, scuffed and in need of repair and paint.

June 18, 2012, Inspector observed a 8' x 10' letter sized pink note taped to a handrail at 14:48 hrs located in the 6th floor hallway. The note stated: "June 4/12 at 0040 hrs, "Equipment out of service, please do not use under any circumstances - equipment name and number "handrail" Problem reported, Do not use as loose". June 19, 2012, Inspector interviewed a staff member from the maintenance department who reported that the handrail; reported in a state of disrepair on June 4, 2012 at 0040 hrs, had not been repaired because there was no concrete available at the home and that their boss had not supplied any. Inspector noted that the handrail was repaired on June 20, 2012.

June 18, 2012 Inspector observed the wall guard/baseboard in a 3rd floor resident room was significantly damaged and in need of repair.

June 19, 2012 Inspector made the following observations of the 2nd Floor balcony: the seams of outdoor carpeting were splitting in several areas and the carpet surface is uneven in several areas posing a tripping hazard. Moss is growing along front railing and along the columns located beside the windows. Inspector observed a vent protruding approximately 6-7 inches from the balcony floor posing a tripping hazard.

June 19, 2012, ESM was unable to describe what processes or procedures were in place in regards to the maintenance and housekeeping programs other than identifying the HIPPO Software. ESM was unable to describe the systems or processes regarding the housekeeping program and stated, "What processes are here? I can't answer that 100%, I was thrown into this position 3 weeks ago".
ESM is currently working half days between 2 LTC homes and explained that their predecessor left on 2 days notice. The ESM will begin working full time in early July.

During the initial tour of the home on June 11, 2012, Inspector 106 noted that the whirlpool tub located in the 5th floor spa room was in a state of disrepair, staff were aware and a pink maintenance requisition was affixed to the side of the tub. On June 19, 2012 Inspector 122 noted that the whirlpool tub remained in a state of disrepair and as the Inspector awaited the arrival of the elevator, Inspector 122 observed a contractor arrive on the unit to repair the tub. June 19, 2012, the ESM reported that the home's contractor, did not have a local repairman and the home was experiencing difficulty in procuring services from the provider in Thunder Bay, ON.

June 21, 2012 at 16:06 hrs, Inspector observed the painted wooden trim, located on the lobby area and throughout the main level of the home was chipped. Flooring located in front entry of the home and council room is grossly worn.

June 21, 2012 at 10:25 hrs Inspector observed the flooring separating at seams near windows in 5th floor TV area. Walls of nursing station and under desk area in need of repair.

June 21, 2012, the ESM reported that in regards to the current state of the refurbished nursing stations, the walls between the upper and lower cabinets which were left in a state of disrepair following the installation of new cupboards,

will be fitted with corkboard. ESM reported that the exposed wires and cables observed under the desk area of the refurbished nursing stations will be enclosed in an accessible manner. The ESM was unable to provide a timeframe for completion for either project. Inspector discussed the general state of disrepair at the home with the ESM who stated "I was warned about this before I took the position". The ESM also reported that he was having difficulty sorting through the previous ESM's records and locating documents. ESM commented that the home had been without an ESM for two years prior to his predecessor.

June 11, 2012, Inspector observed in the spa room on the 6th floor, the towel cupboard base is in disrepair with paint peeling and the baseboard heater has a piece of loose metal. (196)

The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [LTCHA 2007, S. O., c. 8, s. 15 (2) c].

2. June 11, 2012, four resident washrooms on the 6th floor were observed to have feces smeared on the toilet seat, toilet bowl and/or rim of the toilet(196)

June 15, 2012, Inspector observed that the area rug located in north stairwell and through emergency exit # 5 was heavily soiled with dirt, lint and debris (122)

June 15, 2012, Inspector observed the drywall located at the south end of the 5th floor hallway was soiled with dirt and several scuff marks were also noted. Upholstered chairs located in the 5th floor TV area were stained, the fabric in need of cleaning or replacement (122).

On June 15, 2012 on the 6th floor, the Inspector observed the flooring in most resident rooms were stained or soiled with unknown substances. Inspector noted the staining was especially prevalent at the juncture of the flooring and drywall in the resident rooms where flooring material was substituted for baseboards. Dirt dust and debris observed to be accumulated behind doors of most resident rooms. Upholstered chairs located in the 6th floor common area were grossly stained with unknown substances or soiled with dirt (122).

June 18, 2012, Inspector observed a large ball of hair behind the "M North" fire door (122).

June 18, 2012, Inspector observed that the toilet and floor in a resident's washroom was grossly soiled with feces and blood smears (122).

June 18, 2012, Inspector observed that the toilet bowl located in a resident's washroom was smeared with feces (122).

June 19, 2012 Inspector made the following observations of the 2nd Floor balcony: upholstery on the garden swing and gliders was stained, soiled with dirt and worn in some areas. Moss is growing along front railing and along the columns located beside windows. Large areas of carpeting were soiled with mud, dirt and debris (122).

June 19, 2012, ESM was unable to describe the systems or processes regarding the housekeeping program and stated, "What processes are here? I can't answer that 100%, I was thrown into this position 3 weeks ago". ESM reported working half days between 2 LTC homes and reported that their predecessor left on 2 days notice. The ESM will begin working full time in early July (122)

June 21, 2012 at 16:06 hrs, Inspector observed that the sidewalk and pavement located at the front entrance to the home is littered with a large number of cigarette butts. The wall paper in the front lobby, dining room and hallways adjacent to the administration on the main level of the home is grossly stained, soiled with a heavy accumulation of dirt and torn. Corner protectors covering wall paper on corners and columns by the dining room and soiled with a heavy accumulation of dirt. Flooring located in front entry of the home and council room is grossly worn and a heavy accumulation of dirt is permanently embedded into the flooring. Upholstery of the 2 gold chairs located in the lobby is worn and stained with unknown substances (122).

Inspector observed the entrance way to the home, to be unclean with sand and debris and cob webs in the corners of

the doorways. The condition of the entrance way remained unchanged from June 11, 2012 through to the end of the inspection period on June 22, 2012. (196)

June 21, 2012, Inspector interviewed housekeeper 1002 in regards to housekeeping routines. The staff member reported that there is a routine and a checklist that must be followed and documented daily in regards to housekeeping routines and that "a couple of rooms per month" receive deep cleaning adding that resident rooms are also deep cleaned upon discharge of a resident. Following the interview, housekeeper 1002 sought out the Inspector on another unit of the home and stated that they would like to provide additional information. Housekeeper 1002 reported that the deep cleaning is not being completed on schedule because of a cut in housekeeping hours; specifically the cut of housekeeping hours devoted to the main level of the home. Housekeeper 1002 stated that each housekeeper from floors 2 to 6 of the home must now spend 1 hour of their shift devoted to the lobby area of the home. The staff member felt this was putting the housekeepers behind on deep cleaning identified that the residents' rooms are mostly deep cleaned on the discharge of a resident. The Inspector inquired how long it has been since "the cut" of the housekeeper devoted to the 1st floor. The housekeeper reported "a couple of years" (122).

The licensee failed to ensure the home, furnishings and equipment are kept clean and sanitary [LTCHA 2007, S.O. 2007, c. 8, s. 15 (2)(a)

Additional Required Actions:

CO # - 908, 915 were served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services
Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

June 26, 2012, Inspector reviewed CI 1159-000015-12 which describes a resident who injured themself during a fall. The injury resulted in the resident being transferred to hospital. The licensee reported that only one staff member was on the unit prior to the resident's fall. This resident requires the assistance of two staff for transfers. Inspector noted that the home's action to prevent recurrence was to establish a new staffing plan for all care areas in the home to ensure 2 staff are on the unit at all times to provide care for residents who require the assistance of 2 staff members. Inspector reviewed the home's staffing plan noting that it has not been updated to reflect this change. The licensee failed to ensure that the staff plan provides for a mix that is consistent with the residents' assessed care and safety needs. [LTCHA 2007, O.Reg. 79/10, s.31 (3)(a)]

2. Inspector reviewed the home's staffing plan as provided by the home's Administrator on June 22, 2012. Inspector noted the plan and job routines indicate that the third floor should have four PSWs working on the third floor. Inspector observed only three PSWs working on the third floor on every day of the inspection. Inspector spoke with several staff members who all confirmed that only three PSWs work on the third floor day shift. It was identified that previously there had been four PSWs however that the change to three PSWs had been implemented several months prior. Inspector made the following observations on June 19, 2012 on the 3rd Floor: 11:14 hrs, Inspector noted that three scheduled PSWs left the unit to assist in the main floor dining room and that the unit's RPN was alone on the floor to meet the needs of the remaining 27 residents. At 11:24 hrs, resident 1018 was observed by the Inspector to request to go to the bathroom. The RPN responded that the resident would have to wait as two staff members were required to transfer resident 1018 and that currently a second person was not available on the unit to provide this assistance. At 11:25 hrs, Inspector heard a resident yelling (Inspector was in the common area in front of the elevators at this time), a second resident could be heard yelling back at this resident. Inspector entered the first resident's room at 11:30 hrs and saw the resident was lying in bed. The bed was in its highest position. A sling was left under the resident. The resident was visibly agitated but unable to communicate their needs. The RPN was conducting the medication pass and had not responded to the resident's continuous yelling. Inspector had the home's Administrator (who was in the next room) come and observe the resident's condition and reported the concern for the resident's safety. Shortly thereafter, a PSW was paged to return to the third floor unit. The resident's bed was lowered and staff proceeded to get the resident out of bed. The licensee failed to ensure the staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation. [LTCHA 2007, O.Reg. 79/10, s. 31(3)(a)]

3. Inspector reviewed the home's staffing plan on June 22, 2012 and noted that on third floor at 11:00 hrs all four PSWs should be on their lunch break at the same time, leaving the RPN on the floor alone. Inspector noted that the staffing plan indicates the RPN should be conducting the medication pass during this time. Inspector noted that the two PSWs on fifth floor and the two PSWs on sixth floor are also scheduled to be on their lunch breaks at 11:00 hrs, leaving the RPNs on their respective units alone to conduct the medication pass. It was identified by staff members on each respective unit that there

Additional Required Actions:

CO # - 909 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

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

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

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

Findings/Faits saillants :

1. Critical Incident #1159-000015-12 was submitted to the MOHLTC on May 18, 2012. The report outlined circumstances and factors contributing to the fall of resident 900 on May 17, 2012 and concluded that resident's alarmed seat belt had not been turned on by the staff member providing care to the resident. As a result, the resident was able to remove the seat belt and the table top without sounding the alarm and alerting staff. The plan of care for safety, as noted in the Critical Incident report, stated that "the seat belt alarm alerts staff in time to prevent resident from removing both the belt and top". The care that was provided to the resident was not as it was specified in the plan of care. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007, S. O. 2007, c. 8, s. 6 (7)] (196)

2. Inspector observed resident 371 on June 15, 2012 at 1000 hrs, sleeping in a tilt chair with their head leaning forward and unsupported and a seatbelt was not applied. Staff member 1007 was interviewed by the Inspector and stated "no seatbelt is used" for this resident. Inspector then observed staff member 1007 wheel resident 371 to a table in the TV room and despite the resident's head leaning forward; unsupported, the resident was not repositioned. The care plan dated April 26, 2012 identified the use of a front closure seatbelt while the resident is in the wheelchair. The Inspector also noted the identified goal of the mobility care plan was to "maintain upright posture". The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007, S. O. 2007, c. 8, s. 6 (7)] (196)

3. The care plan for resident 557 was reviewed by the Inspector. Inspector noted that the fall prevention interventions included the use of a posey alarm while in bed, a mattress pad alarm, a front opening Velcro seatbelt alarm while in their wheelchair and a floor mat beside their bed for safety. Inspector observed resident 557 on June 19, 2012 sitting in her wheelchair and the front opening Velcro seatbelt was not in place. On June 20, 2012, Inspector observed resident 557 lying in bed. Inspector observed that the mattress pad alarm was not activated. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007, S. O. 2007, c. 8, s. 6 (7)] (196)

4. Inspector reviewed the health care record of resident 532 and noted the following entry in the electronic progress notes, dated June 4, 2012: "Resident had fall on floor, was attempting to reach for call bell. Staff witnessed part of fall, and heard the bang. Had reopened skin tear on right upper arm. Treatment applied. Also did hit head and has goose egg, right at back of their head. Hit head on the wheelchair, call bell [sic] was not within reach. Resident claimed eves [sic] staff, took it away. HIR initiated, and continues. Vitals seem to be consistently stable." On June 20, 2012 at 11:45 hrs, Inspector observed resident 532 lying in bed. The resident's call bell was observed to be beyond the resident's reach. Inspector reviewed the health care record of resident 532 and noted that the plan of care indicates "Call bell/light cord is within reach". The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (7)] (106)

5. Inspector reviewed the health care record including plan of care for resident 47440. Inspector noted the resident is at high nutritional risk and has had significant weight loss. Inspector noted the plan of care includes an intervention to offer the resident oatmeal and chocolate pudding at every meal and snack. Inspector observed the afternoon snack pass on June 18, 2012. Inspector noted the resident was not offered oatmeal or chocolate pudding. Inspector also observed the morning and afternoon snack pass on June 19, 2012 and noted the resident was not offered oatmeal or chocolate pudding. The licensee failed to ensure that the care is provided to the resident as specified in the plan. [LTCHA 2007, S.O. 2007, c.8, s. 6 (7)] (188)

6. Inspector reviewed the plan of care for resident 47453 on June 18, 2012. Inspector noted an intervention related to participation in recreational activities which identified the resident prefers to remain in their room and activation staff or volunteer to visit the resident weekly. Inspector reviewed the activation record on June 20, 2012. Inspector noted that the resident had not received a visit yet in June 2012. Inspector reviewed the record for May 2012 and noted the resident had not received a visit in the month of May. Inspector spoke with recreation aid 1000, who identified that they try to visit residents in their rooms regularly but between scheduled activities and the number of residents who choose to remain in their room it is difficult to regularly visit them all. The licensee failed to ensure that the care is provided to the resident as specified in the plan. [LTCHA 2007, S. O. 2007, c. 8, s. 6 (7)] (188)

7. Inspector reviewed the plan of care for resident 47440 on June 18, 2012. Inspector noted an intervention related to

participation in recreational activities which identified the resident prefers to remain in their room and activation staff or volunteer to visit resident weekly. Inspector reviewed the activation record on June 20, 2012. Inspector noted that the resident had not received a visit yet in June 2012. Inspector reviewed the record for May 2012 and noted the resident had not received a visit in the month of May. Inspector spoke with recreation aid 1000, who identified that they try to visit residents in their rooms regularly but between scheduled activities and the number of residents who choose to remain in their room it is difficult to regularly visit them all. The licensee failed to ensure that the care is provided to the resident as specified in the plan. [LTCHA 2007, S. O. 2007, c.8, s. 6 (7)] (188)

8. Inspector reviewed the plan of care for resident 47440 on June 18, 2012. Inspector noted the resident requires two staff members for all aspects of care related to responsive behaviours and palliative status. Inspector observed on June 19, 2012 at 10:23h as staff member 1001 entered the resident's room and provided the resident's am care alone. The staff member could be heard telling the resident to stop doing that (in French) and do you understand what I'm telling you (in French). The resident could be heard yelling back at the staff member. The staff member completed the care and announced to the two inspectors at the nursing station after the resident's care was done but it was very difficult. The licensee failed to ensure that care is provided to the resident as specified in the plan. [LTCHA 2007, S. O. 2007, c.8, s.6 (7)] (188)

9. Inspector reviewed the health care record of resident 372 and noted that the most recent continence assessment found for the resident was a quarterly continence assessment dated December 31, 2009. This assessment, indicates that the resident gets in and out of bed without help and uses a walker for ambulation. The RAI-MDS assessment dated January 25, 2012, indicates that resident 372 requires the physical assistance to two persons to transfer and the SALT assessment dated May 3, 2012, indicates that the resident requires a wheelchair for her ambulation requirements and transfers via, "Two person side by side with transfer belt". The resident's continent needs were not assessed when their care needs changed. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (10) (b)]

10. Inspector reviewed the health care record of resident 372 and noted that the resident's plan of care, includes the focus, "Pressure ulcers as evidenced by: pressure ulcer stage 2 present" and interventions on caring for the pressure ulcers. The RAI-MDS quarterly assessment dated January 25, 2012 indicates that the resident does not have any current pressure ulcers and the most recent "head to toe assessment" , dated April 25, /2012, indicates no areas of compromised skin areas noted on the resident's body or feet. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (10) (b)]

11. Inspector reviewed the plan of care for resident 372 on June 19, 2012 and noted that the plan of care indicates, "Provide oral hygiene" and "Provide supplies for self oral hygiene". This does not provide clear direction as to whether staff or the resident provides oral hygiene for the resident 372. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (1) (c)]

Additional Required Actions:

CO # - 912, 913, 914 were served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The contents of the 3rd floor medication cart were inspected by the Inspector on June 19, 2012. The Inspector observed that Ativan tablets were supplied in bottles and stored with the residents' regular unit dosed medications which are not double-locked within the medication cart. The licensee failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. [LTCHA 2007, O. Reg. 79/10, s. 129(1)(b)]

2. Inspector observed the 3rd floor cart, which contains prescription creams for residents, unlocked and unattended in the 3rd floor corridor on June 11, 2012 at 11:45 hrs and June 19, 2012 at 09:55 hrs. The licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.[LTCHA 2007, O.Reg.79/10, s. 129(1)(a)(ii)].

3. June 20, 2012 at 15:36 hrs Inspector arrived on the 6th floor and saw the medication cart left unlocked. Inspector was able to gain access to it. The licensee failed to ensure that drugs are stored in an area or medication cart that is secure and locked. [LTCHA 2007, O. Reg. 79/10, s. 129 (1) (a) (ii)].

4. June 20, 2012, Inspector observed that prn Lorazepam was stored in the medication cart with the regularly administered resident medications. This controlled substance was not in the locked cabinet located within the medication cart. Inspector interviewed Staff member 1011 who confirmed that prn Ativan was not stored in the locked cabinet located within the locked medication cart. The licensee failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. [LTCHA 2007, O. Reg. 79/10, s. 129(1)(b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with LTCHA 2007, O. Reg. 79/10, s. 129 (1) (a) to ensure that 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 and with LTCHA 2007, O. Reg. 79/10, s. 129 (1) (b) to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart., to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. June 22, 2012, Inspector reviewed the recorded weights of resident 47440. Inspector noted that in May 2012 the resident’s weight change over the previous six months was 15%. Inspector noted no interdisciplinary assessment. Inspector noted no documentation acknowledging the weight loss. Inspector spoke with the registered dietitian on June 21, 2012 who identified that they were aware of the weight loss but had not completed any assessment as the resident previously refused all weight gain interventions. The licensee failed to ensure that resident who experience a significant weight loss are assessed using an interdisciplinary approach and actions are taken and outcomes are evaluated. [LTCHA 2007, O.Reg. 79/10, s.69]

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 LTCHA 2007, O.Reg. 79/10, s.69 to ensure that residents who experience a significant weight loss are assessed using an interdisciplinary approach and actions are taken and outcomes are evaluated., to be implemented voluntarily.

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

Specifically failed to comply with the following subsections:

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. Staff member 1010 was interviewed by the Inspector on June 20, 2012 and reported that resident 387, keeps prescription treatment creams at the bedside. On June 21, 2012 the Inspector reviewed resident 387's electronic health care record and found no current order that indicated resident 387 could have the prescription creams at their bedside or self administer the prescription treatment creams. The licensee failed to ensure that no resident who is permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except as authorized by a physician. [O. Reg. s. 79/10, s. 131 (7)]

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 LTCHA 2007, O. Reg. 79/10, s. 131 (7) to ensure that no resident who is permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except as authorized by a physician., to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information

Specifically failed to comply with the following subsections:

s. 225. (3) The licensee shall ensure that the fundamental principle set out in section 1 of the Act and the Residents’ Bill of Rights are posted in both English and French. O. Reg. 79/10, s. 225 (3).

Findings/Faits saillants :

1. Inspector conducted a walk through of the home on June 20, 2012. Inspector was unable to locate a French copy of the Residents' Bill of Rights. Inspector spoke with a staff member from the business office who was unable to locate a French copy of the Residents' Bill of Rights. The licensee failed to ensure that the Residents' Bill of Rights is posted in both English and French and communicated. [O.Reg. 79/10, s.225(3)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following subsections:

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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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. Inspector observed the call bell for resident 557 lying on the floor on June 19, 2012 at 10:30hrs and again at 13:45 hrs. An interview was conducted with staff member 1005 on June 19, 2012 at 1350hrs. The staff member stated the resident "will at times use the call bell". Inspector reviewed the care plan for resident 557 and noted the following intervention under the focus of communication "Ensure resident 557 has call bell within reach". The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, assessed and used by residents, staff and visitors at all times. [LTCHA 2007, O. Reg. 79/10, s. 17 (1) a](196)

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. On June 19, 2012, Inspector reviewed the laundry services policy and procedure manual as provided by staff member 1016. The manual did not contain a policy or a procedure that outlined the process to report and locate residents' lost clothing. During an interview with staff member 1016, it was determined that when a missing item is reported to the laundry department, the item is written on the "white board"and then the staff of the laundry department are able to keep an eye out for the item. An interview was conducted with the Environmental Services Manager (ESM)on June 20, 2012 who identified that the laundry staff are to complete a "tracker form" to keep track of missing laundry items and then this is given to the ESM for follow up. The laundry aide was not aware of the use of a "tracker form" to track missing items within the home. The licensee did not have a procedure implemented to report and locate residents' lost clothing. As part of the organized program of laundry services under clause 15 (1) (b) of the Act, the licensee failed to ensure that, (a) procedures are developed and implemented to ensure that, (iv) there is a process to report and locate residents’ lost clothing and personal items. [LTCHA 2007, O.Reg.79/10,s.89.(1)(a)(iv)]

2. The bed linen in a resident's was observed to be thread bare and "see through". On June 15, 2012, the pillow case in a resident's room, was noted to be thread bare. The licensee failed to ensure that, linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours.[LTCHA 2007, O.Reg.79/10,s.89(1)(c)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.

3. A missing or unaccounted for controlled substance.

4. An injury in respect of which a person is taken to hospital.

5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Critical Incident report #1159-000017-12 was submitted to the MOHLTC on May 26, 2012 in regards to a resident injury with transfer to hospital. The report identified the fall had occurred on May 20, 2012 and the transfer to hospital was on May 22, 2012 when the resident developed signs of injury. The home did not notify the Director of the resident injury with transfer to hospital within the required time frame of one business day. The licensee failed to ensure that the Director is informed an injury in respect of which a person is taken to hospital no later that one business day after the occurrence of the incident, followed by the report required under subsection (4). [LTCHA 2007, O. Reg. 79/10, s. 107 (3) 4].

WN #15: 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 subsections:

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

Findings/Faits saillants :

1. During an interview on June 21, 2012, the Administrator reported that the home did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey as a 3rd party was responsible for conducting a survey and they did not seek the advice of Residents' Council. The licensee failed to ensure that the home seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey and in acting on its results. [LTCHA, 2007, S. O. 2007, c. 8, s. 85 (3)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. On June 21, 2012, the DOC reported to the Inspector that the Continence Care and Bowel Management program has not been evaluated and updated annually. The licensee failed ensure that the Continence Care and Bowel Management program was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [O. Reg. 79/10. s. 30 (1) 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 LTCHA 2007, O. Reg. 79/10. s. 30 (1) 3 to ensure that the Continence Care and Bowel Management program be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices., to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. June 19, 2012 at 11:43 hrs it was reported to the inspector that 3rd floor does not currently have a blood pressure cuff on the unit. It was identified that the unit should have one, but that it gets "borrowed" by other floors. Inspector observed as a staff member left the unit to go and find a blood pressure machine for use on the unit. The licensee failed to ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. [LTCHA 2007, O.Reg. 79/10, s.44]

2. June 19, 2012, staff member 1014 who was providing care for resident 372 that day, stated that resident 372, requires set up with oral care. The plan of care for resident 372 indicates, "Provide supplies for self oral hygiene" and "Use soft toothbrush & non abrasive toothpaste". When the staff member was asked to show the Inspector where the oral supplies for resident 372 are kept the staff member was unable to find the supplies. The licensee failed to ensure that supplies, equipment and devices are readily available to meet the nursing and personal care needs of the resident. [LTCHA 2007, O. Reg. 79/10, s. 44]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following subsections:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week.
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week.
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week.
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week.
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The home has 131 licensed beds and the Director of Care (DOC) is required to work regularly in the position on site for at least 35 hours a week. It was noted during the week of June 18, 2012 that the DOC worked as a registered nurse on site and in the home for the purpose of subsection 8(3) of the Act on the evening on June 19, 2012. It was noted that the DOC was not in the home on June 20, 2012. It was noted that the DOC was off on vacation on June 22, 2012. It was identified by the Administrator that no additional registered nurse was on site acting in the role of DOC on June 22, 2012. The DOC worked 22.5 hours on site in the capacity of DOC for the week of June 18, 2012. The licensee failed to ensure that the DOC works on site and in the home for a minimum of 35 hours a week. [O.Reg 79/10, s.213(1)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. Inspector observed resident 47440 on June 18, 2012. Resident 47440 is totally dependent on staff for all care. Inspector noted at 13:54 hrs that resident was in bed. Inspector noted dried orange food particles on the resident's chin and face. Inspector returned and noted at 15:42 hrs that the resident continued to have the dried orange food on their face. The licensee failed to ensure that residents received individualized personal care, including hygiene care and grooming on a daily basis. [LTCHA 2007, O.Reg. 79/10, s.32]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. Inspector reviewed the health care recording including plan of care for resident 47453 on June 21, 2012. Inspector noted the MDS assessment dated April 11, 2012 indicates the resident experiences mild pain daily and receives an analgesic daily. Inspector reviewed the daily PSW documentation and noted in June 2012 that it is documented daily that the resident has a sad/pained/worried facial expression. Inspector reviewed the plan of care and noted no focus related to pain and no interventions for pain management. Inspector was unable to locate a completed pain assessment for the resident. Inspector spoke with staff member 1009 who identified that there is an assessment tool for residents with cognitive impairment but was unable to share a completed assessment for the resident. The licensee failed to ensure the plan of care is based on an assessment of the resident's pain. [O.Reg. 79/10, s.26(3)(10)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

Resident 47453 was first observed to be seated in a tilt wheelchair June 12, 2012 at 09:46h. Inspector further noted the resident in a tilt wheelchair when up through out the inspection. It was noted that the home identified the tilt wheelchair as a restraint within the resident's plan of care and further obtained consent from the SDM and a physician's order recognizing it as a restraint. Inspector reviewed the June 2012 restraint records for resident 47453 and noted the column for registered staff assessment contained only one signature on June 14, 2012 day shift. The record contained no other documentation of the registered staff assessment of the restraint. Inspector spoke with staff member 1009 who identified they did not monitor the resident's tilt wheelchair restraint because they did not consider it a restraint. There was a monitoring process in place that was being followed by the PSWs but not by the RPN because the RPN did not consider the tilt wheelchair a restraint. The licensee failed to ensure that the resident's condition has been reassessed and the effectiveness of the restraining evaluated by a member of the registered staff at least every eight hours and at any other time based on the resident's condition. [LTCHA 2007, O.Reg. 79/10, s.110(2)(6)]

WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

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

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

Findings/Faits saillants :

1. Inspector observed resident 47453 on June 12, 2012 at 09:44 hrs and noted the resident had a white hand towel tucked into their shirt collar like a bib. Inspector noted on June 19, 2012 at 09:55 hrs that resident 47453, who was in the common area in front of the elevator, had a white towel tucked into their shirt collar like a bib. Inspector observed that this towel was still tucked into their shirt collar like a bib at 10:53 hrs. The licensee failed to ensure that residents' right to be treated with courtesy and respect and in a way that respect's the resident's dignity is fully respected and promoted. [LTCHA 2007, S.O. 2007, c.8, s.3(1)(1)]

2. June 20, 2012 at 10:11 hrs, Inspector overheard resident 47514 speaking to staff member 1007 from another home area regarding the mornings events. Resident 47514 was interviewed by the Inspector and reported that they were not woken up in time that morning and almost missed breakfast. Resident 47514 added that their wheelchair was not positioned beside the bed; therefore, the resident was unable to self transfer. Resident 514 stated "I was ringing and ringing my buzzer and no one was coming until 7:55 am." "I had no time to wash my face or hands before breakfast, I hate to eat before washing, I was taught to wash my hands and face before eating breakfast at home, I don't think that's right." The licensee failed to ensure that residents' right to be treated with courtesy and respect and in a way that respects the resident's dignity is fully respected and promoted. [LTCHA 2007, S.O. 2007, c.8, s.3(1)(1)]

3. June 18, 2012 at 1353 hrs, housekeeper 1017 was observed by the inspector in the resident lounge near the nursing station. Shortly after the housekeeper entered the lounge resident 372 was observed to be pushed from where they had been watching TV to a position parallel to the nursing station and facing away from the TV. The housekeeper was then over heard to say "can't stay in here the floor needs to be washed" in a gruff voice and was heard making multiple comments about not being able to wash the floor with the residents in the lounge area. Three of the residents left the lounge area and went to a nearby TV lounge and three residents remained in the nursing lounge. Inspector 106 observed the housekeeper ask two of the residents who remained seated in the lounge near the nursing station to raise their feet straight out in front of them, pivot to the right and hold their feet in this position while the housekeeper washed the floor under the chairs that the residents were sitting on. The licensee failed to ensure the right of every resident to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity was fully respected and promoted. [LTCHA, 2007, S. O. 2007, c. 8, s. 3 (1) 1]

4. Inspector observed on June 15, 2012 as RPN 1009 administered two injections to residents while they were sitting in the common area in front of the elevator. Inspector observed as the RPN assisted resident 1020 to remove their arm from their long sleeve shirt and administer the injection. Inspector then observed as the RPN returned to the common area and administered an injection to resident 1019 while the resident was sitting in front of the elevator in the main common area. The licensee failed to ensure that residents right to be afforded privacy in treatment is fully respected and promoted. [LTCHA 2007, S.O. 2007, c.8, s.3(1)(8)]

5. On June 13, 2012, between 1100 and 1120hrs, the Inspector observed staff members of a home area yelling loudly to each other down the unit corridor discussing resident care needs, stating "poop everywhere", stating "need to take the resident to the washroom now". Numerous residents, staff of other disciplines and Inspector present in nursing station area and able to hear discussions. The licensee failed to ensure that residents right to be afforded privacy in treatment is fully respected and promoted. [LTCHA 2007, S.O. 2007, c.8, s.3(1)(8)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following subsections:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
1. Treatments and interventions to promote continence.
2. Treatments and interventions to prevent constipation, including nutrition and hydration protocols.
3. Toileting programs, including protocols for bowel management.
4. Strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aids.
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

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

Findings/Faits saillants :

1. On June 21, 2012, resident 47514 reported that their continence product is not always changed as required. Resident 47514 stated that nursing staff on the unit have told her "no, we don't have time". The resident was unable to provide the names of these staff members. Inspector reviewed the resident's health care record and was unable to locate a quarterly continence assessment. Inspector reviewed the Admission Assessment Checklist and noted that it had been initialed, indicating that it was completed. Inspector reviewed the resident's health care record and was unable to locate a completed admission continence assessment in the resident's paper health care record, electronic health care record or the continence assessment contained within RAI MDS. Inspector interviewed staff member 1015 regarding the frequency that continence assessments are completed for each resident. The staff member reported that continence assessments are only completed on admission to the home and not quarterly. The licensee failed to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [LTCHA 2007, O. Reg 79/10, s. 51 (2) a]

2. During an interview on June 21, 2012, the DOC reported that a third party is responsible for the annual satisfaction survey and the results are are not shared with staff of the home. The licensee failed to ensure that the Continence Care Program includes an annual resident satisfaction evaluation of the continence care products in consultation with residents, substitute decision-makers and direct care staff and takes into account the evaluation when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. [LTCHA 2007, O. Reg. 79/10, s. 51 (1) 5]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. Resident 47514 was interviewed by the Inspector on June 12, 2012 and stated that they are not offered a choice of bath or shower. The resident stated it's kind of tough for a one legged person getting in and out the shower, I prefer a bath". Inspector reviewed the health care record of resident 47514 and noted that the resident is to be offered choices regarding care. Staff member 1013 was interviewed by the Inspector on June 18, 2012 and reported that most residents on the 2nd floor receive showers, 1 resident goes to the 3rd floor to have a bath. Staff member 1012 was interviewed by the Inspector on June 19, 2012 and reported that residents who wish to have baths rather than showers are accommodated in Spa rooms on other home areas. The licensee failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.[LTCHA 2007, O. Reg 79/10, s. 33 (1)]

2. Resident 47364 was interviewed by the Inspector on June 12, 2012 and stated that their method of bathing is determined "on the schedule". The resident added,"we haven't got a tub on this floor so now it's showers, they took the tub out; I would prefer a bath". The resident's plan of care states that the resident will be offered a choice regarding her care. Staff member 1013 was interviewed by the Inspector on June 18, 2012 and reported that most residents on the 2nd floor receive showers, 1 resident goes to the 3rd floor to have a bath. Staff member 1012 was interviewed by the Inspector on June 19, 2012 and reported that residents who wish to have baths rather than showers are accommodated in Spa rooms on other home areas. The licensee failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. [LTCHA 2007, O. Reg 79/10, s. 33 (1)]

Issued on this 15th day of October, 2012

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

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROSE-MARIE FARWELL (122), LAUREN TENHUNEN (196), MARGOT BURNS-PROUTY (106), MELISSA CHISHOLM (188)
Inspection No. / No de l'inspection :	2012_053122_0014
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Date of Inspection / Date de l'inspection :	Jun 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25, 26, 28, Jul 4, 5, 6, Aug 21, 22, 23, 24, Sep 20, 21, Oct 3, 11, 15, 2012
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	LAKEHEAD MANOR 135 SOUTH VICKERS STREET, THUNDER BAY, ON, P7E-1J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SHELEIGH MCMILLAN

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 901 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (7) The licensee shall ensure that food and beverages that are appropriate for the residents' diets are accessible to staff and available to residents on a 24-hour basis. O. Reg. 79/10, s. 71 (7).

Order / Ordre :

The licensee shall ensure that food and beverages that are appropriate for the residents' diets are accessible to staff and available to residents on a 24-hour basis. O. Reg. 79/10, s. 71 (7)

Grounds / Motifs :

1. Staff member 1006 was interviewed by the Inspector on June 20, 2012 and reported that residents who receive regular and minced diets have access to food, such as, bread and crackers which are kept stocked on the unit at all times. Staff member 1006 reported that there are not always options available for residents who require a puree diet. The licensee failed to ensure that appropriate food and beverages for all residents diets are accessible to staff and available to residents on a 24-hour basis. [LTCHA 2007, O. Reg. 79/10, s. 71 (7)] (106)
2. Staff member 1004 was interviewed by the Inspector on June 13, 2012, and reported that each unit no longer has a stocked pantry with puddings, sandwiches and beverages for residents who are hungry during the night. Staff member 1005 was interviewed by the Inspector on June 20, 2012 and stated "snacks and beverages are not always available 24 hours a day". Staff member 1005 added that the units are no longer stocked with snacks and beverages during the night. The licensee failed to ensure that food and beverages that are appropriate for the residents' diets are accessible to staff and available to residents on a 24-hour basis. [LTCHA 2007, O. Reg. 79/10, s. 71 (7)] (196)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2012

Order # / Ordre no : 902 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Grounds / Motifs :

1. Inspector observed the afternoon snack pass on third floor on June 19, 2012. Inspector noted that the snack cart did not leave the common area in front of the elevators. Inspector noted that a staff member took a spoonful of puree food into resident 47440's room. Inspector observed as the staff member exited the room seconds later identifying loudly that the resident refused. The inspector noted that the staff member did not bring in any fluids to offer to the resident. The licensee failed to ensure that each resident is offered a minimum of a between meal beverage in the morning and afternoon and a beverage in the evening after dinner. [LTCHA 2007, O.Reg. 79/10, s.71 (3)] (188)
2. Inspector observed the am snack pass on third floor on June 19, 2012. Inspector noted that the snack cart did not leave the common area in front of the elevators. Inspector noted at no time did any staff members enter resident 47440's room to offer the resident a beverage. The licensee failed to ensure that each resident is offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner. [LTCHA 2007, O.Reg. 79/10, s.71 (3)] (188)
3. Inspector observed resident 47440 on June 18, 2012. Inspector observed as the afternoon beverage and snack pass occurred on third floor. Inspector noted that it was completed by several different staff members. Inspector noted that at no time during or after the pass did any staff member enter resident 47440's room to offer the resident a beverage or snack. The licensee failed to ensure that each resident is offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner and a snack in the afternoon and evening. [LTCHA 2007, O.Reg. 79/10, s.71 (3)] (188)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2012

Order # / Ordre no : 903

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
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.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Order / Ordre :

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).

Grounds / Motifs :

1. Inspector reviewed the health care record of resident 47569 who was admitted to the home on December 19, 2011. Inspector found no documented evidence of TB Screening by 2 Step Mantoux Skin Test.

Inspector reviewed the health care record of resident 47532 who was admitted to the home on August 18, 2011. Inspector found no documented evidence of TB Screening by 2 Step Mantoux Skin Test.

Inspector reviewed the health care record of resident 47550 who was admitted to the home on April 10, 2011.Inspector found no documented evidence of TB Screening by 2 Step Mantoux Skin Test.

The licensee failed to ensure that 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. [LTCHA 2007, O. Reg. 79/10, s. 229 (10)1]. (122)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2012

Order # / Ordre no : 904 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that a resident who is dependent on staff to be repositioned has been repositioned at least every two hours. O.Reg. 79/10, s. 50 (2) (d)

Grounds / Motifs :

1. Inspector reviewed the health care record for resident 47368. Inspector noted that the resident is at high risk for pressure ulcers and unable to reposition independently. Inspector noted the resident sitting in a tilt wheelchair with a lap belt in the common area in front of the elevator on third floor on June 15, 2012. Inspector observed the resident from 09:46h until 12:04h. Inspector noted at no time during this observation was the resident repositioned. The licensee failed to ensure that a resident who is dependent on staff to be repositioned has been repositioned at least every two hours. [LTCHA 2007, O.Reg. 79/10, s.50 (2) (d)] (188)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 28, 2012

Order # / Ordre no : 905 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, of clinically indicated. O. Reg. 79/10, s. 50 (2) (b) (iv)

Grounds / Motifs :

1. Inspector noted that resident 47440 had altered skin integrity. Inspector reviewed the resident's health care record including weekly skin assessments conducted by registered nursing staff. Inspector noted the documentation indicated the resident's wound was first noted on January 21, 2012. Inspector noted between January 21, 2012 and June 15, 2012 that a weekly skin assessment by a member of the registered nursing staff was completed for seven weeks of the twenty two week period. The licensee failed to ensure that a resident who is exhibiting altered skin integrity receives an assessment by a member of the registered nursing staff at least weekly. [LTCHA, 2007, O. Reg. 79/10, s.50 (2) (b) (iv)] (188)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 28, 2012

Order # / Ordre no : 906 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents.
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9. (1).

Order / Ordre :

The licensee shall ensure that all doors leading to non-residential areas will be equipped with locks to restrict unsupervised access to those areas by residents. [LTCHA 2007, O. Reg 79/10, s. 9 (1) 2.]

Grounds / Motifs :

1. June 21, 2012 at 14:40 hrs, Inspector noted the door from the main floor dining room is not kept locked. Inspector was able to open the door and enter into the hallway. Inspector was then able to open an unlocked door labelled "fire door" and enter into a small storage area. This Inspector spoke with staff member 1003 from maintenance who identified the door should be locked. The licensee failed to ensure doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents. [LTCHA 2007, O.Reg. 79/10, s.9 (1) 2)] (188)
2. June 21, 2012 at 14:40 hrs, Inspector noted the door off the main floor dining room is not kept locked. Inspector was able to open the door and enter into the hallway. Inspector was then able to open a door labelled kitchen and enter into the kitchen. This door was not locked. The licensee failed to ensure doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents. [LTCHA 2007, O.Reg. 79/10, s.9 (1) 2] (106)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 28, 2012

Order # / Ordre no : 907 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents.
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9. (1).

Order / Ordre :

The licensee shall ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to will be kept closed and locked. O.Reg. 79/10, s.9 (1) 1 (i)

Grounds / Motifs :

1. June 19, 2012 at 1507 hrs, Inspector observed the alarmed exterior door at end of laundry/kitchen hallway propped open to the outside. No staff members were observed in the general vicinity of the open door. Inspector contacted the Environmental Services Manager and the door was closed and locked. The licensee failed to ensure doors leading to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to are kept closed and locked. [LTCHA 2007, O.Reg. 79/10, s.9 (1) 1 (i)] (196)
2. June 19, 2012 at 1507 hrs, Inspector noted the door off the main floor dining room is not kept locked. Inspector was able to open the door and enter into the hallway. Inspector was then able to open a second unlocked door and enter into the stairwell. Inspector noted that no alarm sounded when either of the doors were opened. Inspector noted no door access control system on the door. Inspector spoke with maintenance staff member 1021 who confirmed there is no lock on the doors and that there has never been any lock or alarm on the door leading to the stairway. The licensee failed to ensure doors leading to the stairway are kept closed and locked. [LTCHA 2007, O.Reg. 79/10, s.9 (1) 1 (i)] (188)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 28, 2012

Order # / Ordre no : 908 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA 2007, c. 8, s. 15 (2) a. The compliance plan shall include detailed information regarding how the licensee shall ensure that the home, furnishings and equipment will be kept clean and sanitary.

The plan is to be submitted in writing to Long Term Care Homes Inspector, Gail Peplinkskie, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 603, Sudbury, ON, P3E 6A5 by November 30, 2012. The plan shall be fully implemented by December 28, 2012.

Grounds / Motifs :

1. June 11, 2012, four resident washrooms on the 6th floor were observed to have feces smeared on the toilet seat, toilet bowl and/or rim of the toilet(196)

June 15, 2012, Inspector observed that the area rug located in north stairwell and through emergency exit # 5 was heavily soiled with dirt, lint and debris (122)

June 15, 2012, Inspector observed the drywall located at the south end of the 5th floor hallway was soiled with dirt and several scuff marks were also noted. Upholstered chairs located in the 5th floor TV area were stained, the fabric in need of cleaning or replacement (122).

On June 15, 2012 on the 6th floor, the Inspector observed the flooring in most resident rooms were stained or soiled with unknown substances. Inspector noted the staining was especially prevalent at the juncture of the flooring and drywall in the resident rooms where flooring material was substituted for baseboards. Dirt dust and debris observed to be accumulated behind doors of most resident rooms. Upholstered chairs located in the 6th floor common area were grossly stained with unknown substances or soiled with dirt (122).

June 18, 2012, Inspector observed a large ball of hair behind the "M North" fire door (122).

June 18, 2012, Inspector observed that the toilet and floor in a resident's washroom was grossly soiled with feces and blood smears (122).

June 18, 2012, Inspector observed that the toilet bowl located in a resident's washroom was smeared with feces (122).

June 19, 2012 Inspector made the following observations of the 2nd Floor balcony: upholstery on the garden swing and gliders was stained, soiled with dirt and worn in some areas. Moss is growing along front railing and along the columns located beside windows. Large areas of carpeting were soiled with mud, dirt and debris (122).

June 19, 2012, ESM was unable to describe the systems or processes regarding the housekeeping program and

stated, “What processes are here? I can't answer that 100%, I was thrown into this position 3 weeks ago”. ESM reported working half days between 2 LTC homes and reported that their predecessor left on 2 days notice. The ESM will begin working full time in early July (122)

June 21, 2012 at 16:06 hrs, Inspector observed that the sidewalk and pavement located at the front entrance to the home is littered with a large number of cigarette butts. The wall paper in the front lobby, dining room and hallways adjacent to the administration on the main level of the home is grossly stained, soiled with a heavy accumulation of dirt and torn. Corner protectors covering wall paper on corners and columns by the dining room and soiled with a heavy accumulation of dirt. Flooring located in front entry of the home and council room is grossly worn and a heavy accumulation of dirt is permanently embedded into the flooring. Upholstery of the 2 gold chairs located in the lobby is worn and stained with unknown substances (122).

Inspector observed the entrance way to the home, to be unclean with sand and debris and cob webs in the corners of the doorways. The condition of the entrance way remained unchanged from June 11, 2012 through to the end of the inspection period on June 22, 2012. (196)

June 21, 2012, Inspector interviewed housekeeper 1002 in regards to housekeeping routines. The staff member reported that there is a routine and a checklist that must be followed and documented daily in regards to housekeeping routines and that "a couple of rooms per month" receive deep cleaning adding that resident rooms are also deep cleaned upon discharge of a resident. Following the interview, housekeeper 1002 sought out the Inspector on another unit of the home and stated that they would like to provide additional information. Housekeeper 1002 reported that the deep cleaning is not being completed on schedule because of a cut in housekeeping hours; specifically the cut of housekeeping hours devoted to the main level of the home. Housekeeper 1002 stated that each housekeeper from floors 2 to 6 of the home must now spend 1 hour of their shift devoted to the lobby area of the home. The staff member felt this was putting the housekeepers behind on deep cleaning identified that the residents' rooms are mostly deep cleaned on the discharge of a resident. The Inspector inquired how long it has been since "the cut" of the housekeeper devoted to the 1st floor. The housekeeper reported "a couple of years" (122).

The licensee failed to ensure the home, furnishings and equipment are kept clean and sanitary [LTCHA 2007, S.O. 2007, c. 8, s. 15 (2)(a) (122)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 28, 2012

Order # /
Ordre no : 909

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the staffing plan will (a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation LTCHA 2007, O. Reg. 79/10, s. 31 (3) a

Grounds / Motifs :

1. Inspector reviewed the home's staffing plan on June 22, 2012 and noted that on third floor at 11:00 hrs all four PSWs should be on their lunch break at the same time, leaving the RPN on the floor alone. Inspector noted that the staffing plan indicates the RPN should be conducting the medication pass during this time. Inspector noted that the two PSWs on fifth floor and the two PSWs on sixth floor are also scheduled to be on their lunch breaks at 11:00 hrs, leaving the RPNs on their respective units alone to conduct the medication pass. It was identified by staff members on each respective unit that there are residents who require two staff for all aspects of care on these units. The licensee failed to ensure their staffing plan provides for a staffing mix that is consistent with the residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation. [LTCHA 2007, O. Reg. 79/10, s.31 (3) (a) (188)
2. Inspector reviewed the home's staffing plan as provided by the home's Administrator on June 22, 2012. Inspector noted the plan and job routines indicate that the third floor should have four PSWs working on the third floor. Inspector observed only three PSWs working on the third floor on every day of the inspection. Inspector spoke with several staff members who all confirmed that only three PSWs work on the third floor day shift. It was identified that previously there had been four PSWs however that the change to three PSWs had been implemented several months prior. Inspector made the following observations on June 19, 2012 on the 3rd Floor: 11:14 hrs, Inspector noted that three scheduled PSWs left the unit to assist in the main floor dining room and that the unit's RPN was alone on the floor to meet the needs of the remaining 27 residents. At 11:24 hrs, resident 1018 was observed by the Inspector to request to go to the bathroom. The RPN responded that the resident would have to wait as the resident required two staff members to transfer and that currently a second person was not available on the unit to provide this assistance. At 11:25 hrs, Inspector heard a resident yelling (Inspector was in the common area in front of the elevators at this time), a second resident could be heard yelling back at this resident. Inspector entered the first residents' room at 11:30 hrs and saw the resident was lying in bed. The bed was in its highest position. A sling was left under the resident. The resident was visibly agitated but unable to communicate their needs. The RPN was conducting the medication pass and had not responded to the resident's continuous yelling. Inspector had the home's Administrator (who was in the next room) come and observe the resident's condition and reported the concern for the resident's safety. Shortly thereafter, a PSW was paged to return to the third floor unit. The resident's bed was lowered and staff proceeded to get the resident out of bed. The licensee failed to ensure the staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation. [LTCHA 2007, O.Reg. 79/10, s. 31(3) (a)] (188)
3. June 26, 2012, Inspector reviewed CI 1159-000015-12 which describes a resident who injured themself during a fall. The injury resulted in the resident being transferred to hospital. The licensee reported that only one staff member was on the unit prior to the resident's fall. This resident requires the assistance of two staff for transfers. Inspector noted that the home's action to prevent recurrence was to establish a new staffing plan for all care areas in the home to ensure 2 staff are on the unit at all times to provide care for residents who require the assistance of 2 staff members. Inspector reviewed the home's staffing plan noting that it has not been updated to reflect this change. The licensee failed to ensure that the staff plan provides for a mix that is consistent with the residents' assessed care and safety needs. [LTCHA 2007, O. Reg. 79/10, s.31 (3) (a)] (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 28, 2012

Order # / Ordre no : 910

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (8) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and
(b) a written plan for responding to infectious disease outbreaks. O. Reg. 79/10, s. 229 (8).

Order / Ordre :

The licensee shall ensure that there are in place, (a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts. O. Reg. 79/10, s. 229 (8) a.

Grounds / Motifs :

1. During an interview on June 21, 2012, the DOC reported that the procedures staff are to follow when caring for resident 47401 are to gown, glove and mask before entering the room of the ESBL positive resident. The DOC also reported that staff should not flush the infected urine down the toilet in the washroom that is shared by her roommate who is not ESBL positive. Staff are to take the urine to the "hopper" to dispose of it. On June 21, 2012, two staff members on the home area reported to the Inspector that they only apply gloves prior to and while providing care to the ESBL positive resident. One staff member was unaware of any other interventions that were to be implemented to prevent the spread of ESBL. The other staff member reported that when draining the resident's catheter bag, they drain it into a can and then empty the can into the resident's toilet. The can and toilet are then disinfected. Both staff members stated that they were unaware of what infection the resident was suffering from and only one of the staff members was aware that the infection was transmitted through urine. Inspector reviewed the health care record of resident 47401 and noted that the resident's plan of care does not include interventions on what precautions staff should implement to prevent the spread of ESBL while caring for resident 47401. [LTCHA 2007, O. Reg. 79/10, s. 229 (8) (a)] (106)
2. On June 19, 2012, Inspector observed a contact precautions sign and infection control cart located outside of a resident room. Inspector reviewed the 24 hr report which did not identify any active infections on the unit as per the home's infection control protocol. Inspector interviewed the staff member who was observed administering medications to the residents on the unit. The staff member, whose name is unknown reported that they were new and orientating to the unit and were unaware of the purpose of the signage. Inspector interviewed staff member 1007 regarding the contact precautions signage located outside of the resident room. The staff member pointed to the resident seated next to them in the wheelchair, in the TV area and stated "we were told the resident doesn't have to stay in their room" and to wear gloves when providing care. Inspector inquired if the resident was infected with MRSA, staff member 1007 nodded. Inspector reviewed the resident's health care record and noted that the resident's urine was infected with Extended Spectrum Beta Lactamase producing bacteria (ESBL). On June 20, 2012, the Inspector interviewed staff member 1008 who confirmed that resident 47401 was infected with ESBL. The staff member stated that they had expressed concern regarding resident 47401 sharing a room with another resident and had inquired if the resident shouldn't be segregated in a private room. Staff member 1008 added that staff were informed resident 47401 did not require a private room, or cohorting because the privacy curtain was barrier enough and that the roommate of resident 47401 was tested for ESBL and results were negative. Staff member 1008 explained that resident 47401 did not physically use the toilet, but the resident's room mate does. Staff member 1008 explained that the contents of resident 47401's catheter bag are emptied into a container and the urine disposed of in the toilet. Both the container and the toilet are to be disinfected and staff were to wear gloves when providing care. The licensee failed to ensure that there was in place an outbreak management system for detecting, managing and controlling infectious diseases outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts. [LTCHA 2007, O. Reg. 79/10, s. 229 (8) a] (122)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2013

Order # / Ordre no : 911 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;
(c) that the local medical officer of health is invited to the meetings;
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

Order / Ordre :

The licensee shall ensure, (a) that there is an interdisciplinary team approach in the co-ordination and implementation of the infection control program LTCHA 2007, O. Reg. 79/10, s. 229 (2) a.

Grounds / Motifs :

1. On June 21, 2012, the Inspector interviewed the Director of Care (DOC) regarding the home's Infection Prevention and Control Program. The DOC reported that the home does not currently have an Infection Prevention and Control Team. The licensee failed to ensure that here is an interdisciplinary team approach in the co-ordination and implementation of the Infection Prevention and Control program. [LTCHA 2007, O. Reg., s. 229 (2) (a)] (106)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2013

Ministry of Health and Long-Term Care

Ministére 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

Order # / Ordre no : 912

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that there is a written plan of care for each resident that sets out (c) clear directions to staff and others who provide direct care to the resident. LTCHA 2007, c. 8, s. 6 (1) c.

Grounds / Motifs :

1. Inspector reviewed the plan of care for resident 372 on June 19, 2012 and noted that the plan of care indicates, "Provide oral hygiene" and "Provide supplies for self oral hygiene". This does not provide clear direction as to whether staff or the resident provides oral hygiene for the resident 372. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (1) (c)] (106)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 09, 2013

Order # / Ordre no : 913 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary. LTCHA 2007, c. 8, s. 6 (10) b.

Grounds / Motifs :

1. Inspector reviewed the health care record of resident 372 and noted that the most recent continence assessment found for the resident was a quarterly continence assessment dated December 31, 2009. This assessment, indicates that the resident gets in and out of bed without help and uses a walker for ambulation. The RAI-MDS assessment dated January 25, 2012, indicates that resident 372 requires the physical assistance to two persons to transfer and the SALT assessment dated May 3, 2012, indicates that the resident requires a wheelchair for ambulation and transfers via, "Two person side by side with transfer belt". The resident's continence needs were not assessed when their care needs changed. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (10) (b)] (106)
2. Inspector reviewed the health care record of resident 372 and noted that the resident's plan of care, includes the focus, "Pressure ulcers as evidenced by: pressure ulcer stage 2 present" and interventions on caring for the pressure ulcers. The RAI-MDS quarterly assessment dated January 25, 2012 indicates that the resident does not have any current pressure ulcers and the most recent "head to toe assessment", dated April 25, /2012, indicates no areas of compromised skin areas noted on the resident's body or feet. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (10) (b)] (106)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 09, 2013

Order # / Ordre no : 914 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Grounds / Motifs :

1. Critical Incident #1159-000015-12 was submitted to the MOHLTC on May 18, 2012. The report outlined circumstances and factors contributing to the fall of resident 900 on May 17, 2012 and concluded that resident's alarmed seat belt had not been turned on by the staff member providing care to the resident. As a result, the resident was able to remove the seat belt and the table top without sounding the alarm and alerting staff. The plan of care for safety, as noted in the Critical Incident report, stated that "the seat belt alarm alerts staff in time to prevent resident from removing both the belt and top". The care that was provided to the resident was not as it was specified in the plan of care. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007, S. O. 2007, c. 8, s. 6 (7)] (196)

2. Inspector observed resident 371 on June 15, 2012 at 1000 hrs, sleeping in a tilt chair with their head leaning forward and unsupported and a seatbelt was not applied. Staff member 1007 was interviewed by the Inspector and stated "no seatbelt is used" for this resident. Inspector then observed staff member 1007 wheel resident 371 to a table in the TV room and despite the resident's head leaning forward; unsupported, the resident was not repositioned. The care plan dated April 26, 2012 identified the use of a front closure seatbelt while the resident is in the wheelchair. The Inspector also noted the identified goal of the mobility care plan was to "maintain upright posture". The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007, S. O. 2007, c. 8, s. 6 (7)] (196)

3. The care plan for resident 557 was reviewed by the Inspector. Inspector noted that the fall prevention interventions included the use of a posey alarm while in bed, a mattress pad alarm, a front opening Velcro seatbelt alarm while in their wheelchair and a floor mat beside their bed for safety. Inspector observed resident 557 on June 19, 2012 sitting in her wheelchair and the front opening Velcro seatbelt was not in place. On June 20, 2012, Inspector observed resident 557 lying in bed. Inspector observed that the mattress pad alarm was not activated. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007, S. O. 2007, c. 8, s. 6 (7)] (196)

4. Inspector reviewed the health care record of resident 532 and noted the following entry in the electronic progress notes, dated June 4, 2012: "Resident had fall on floor, was attempting to reach for call bell. Staff witnessed part of fall, and heard the bang. Had reopened skin tear on right upper arm. Treatment applied. Also did hit head and has goose egg, right at back of their head. Hit head on the wheelchair, call bell [sic] was not within reach. Resident claimed eves [sic] staff, took it away. HIR initiated, and continues. Vitals seem to be consistently stable." On June 20, 2012 at
11:45 hrs, Inspector observed resident 532 lying in bed. The resident's call bell was observed to be beyond the resident's reach. Inspector reviewed the health care record of resident 532 and noted that the plan of care indicates "Call bell/light cord is within reach". The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (7)] (106)

5. Inspector reviewed the health care record including plan of care for resident 47440. Inspector noted the resident is at high nutritional risk and has had significant weight loss. Inspector noted the plan of care includes an intervention to offer the resident oatmeal and chocolate pudding at every meal and snack. Inspector observed the afternoon snack pass on June 18, 2012. Inspector noted the resident was not offered oatmeal or chocolate pudding. Inspector also observed the morning and afternoon snack pass on June 19, 2012 and noted the resident was not offered oatmeal or chocolate pudding. The licensee failed to ensure that the care is provided to the resident as specified in the plan. [LTCHA 2007, S.O. 2007, c.8, s. 6 (7)] (188)

6. Inspector reviewed the plan of care for resident 47453 on June 18, 2012. Inspector noted an intervention related to participation in recreational activities which identified the resident prefers to remain in their room and activation staff or volunteer to visit the resident weekly. Inspector reviewed the activation record on June 20, 2012. Inspector noted that the resident had not received a visit yet in June 2012. Inspector reviewed the record for May 2012 and noted the resident had not received a visit in the month of May. Inspector spoke with recreation aid 1000, who identified that they try to visit residents in their rooms regularly but between scheduled activities and the number of residents who choose to remain in their room it is difficult to regularly visit them all. The licensee failed to ensure that the care is provided to the resident as specified in the plan. [LTCHA 2007, S. O. 2007, c. 8, s. 6 (7)] (188)

7. Inspector reviewed the plan of care for resident 47440 on June 18, 2012. Inspector noted an intervention related to participation in recreational activities which identified the resident prefers to remain in their room and activation staff or volunteer to visit resident weekly. Inspector reviewed the activation record on June 20, 2012. Inspector noted that the resident had not received a visit yet in June 2012. Inspector reviewed the record for May 2012 and noted the resident had not received a visit in the month of May. Inspector spoke with recreation aid 1000, who identified that they try to visit residents in their rooms regularly but between scheduled activities and the number of residents who choose to remain in their room it is difficult to regularly visit them all. The licensee failed to ensure that the care is provided to the resident as specified in the plan. [LTCHA 2007, S. O. 2007, c.8, s. 6 (7)] (188)

8. Inspector reviewed the plan of care for resident 47440 on June 18, 2012. Inspector noted the resident requires two staff members for all aspects of care related to responsive behaviours and palliative status. Inspector observed on June 19, 2012 at 10:23h as staff member 1001 entered the resident's room and provided the resident's am care alone. The staff member could be heard telling the resident to stop doing that (in French) and do you understand what I'm telling you (in French). The resident could be heard yelling back at the staff member. The staff member completed the care and announced to the two inspectors at the nursing station after the resident's care was done but it was very difficult. The licensee failed to ensure that care is provided to the resident as specified in the plan. [LTCHA 2007, S. O. 2007, c.8, s.6 (7)] (188) (122)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 09, 2013

Order # / Ordre no : 915 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA 2007, c. 8, s. 15 (2) c. The compliance plan shall include detailed information regarding the repairs to be made to resident and non-resident areas of the home and will identify expected dates of completion.

The plan is to be submitted in writing to Long Term Care Homes Inspector, Gail Peplinkskie, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 603, Sudbury, ON, P3E 6A5 by November 30, 2012. The plan shall be fully implemented by May 31, 2013.

Grounds / Motifs :

1. June 15, 2012, Inspector observed the walls in the 3rd floor spa room were heavily gouged, the paint chipped, a 4x4 inch piece of drywall was cut from wall located behind the tub. Grip tape on floor is worn away in most areas. The finish on cabinet located in corner of spa room was grossly peeling and the chip board construction along bottom of cabinet was noted to be rotting. The paint on supply room door located within the 3rd floor spa room was grossly chipped.

June 15, 2012, Inspector observed the flooring located on the north end of the 5th floor hallway was heavily scuffed. The handrails along both sides of the 5th floor corridor were scratched and the paint was worn. The flooring at the entrance to a resident's room was lifting and the flooring located by the 5th floor, south stairwell exit was noted to have a large gouge. The elevator doors located by the 5th floor nursing station were heavily scuffed towards the bottom of the frames.

June 15, 2012, Inspector observed the drywall and baseboards located at the south end of the 6th floor corridor were heavily scuffed. The flooring in most residents' rooms were stained or soiled with unknown substances, Inspector noted the staining was especially prevalent at the juncture of the flooring and drywall in the resident rooms where flooring material was substituted for baseboards. A large piece of flooring was missing and posed a tripping hazard, immediately inside the doorway of 6th floor TV room located beside the Spa. Walls of the public washroom, north side corridor, was chipped, scuffed and in need of repair and paint.

June 18, 2012, Inspector observed a 8' x 10' letter sized pink note taped to a handrail at 14:48 hrs located in the 6th floor hallway. The note stated: "June 4/12 at 0040 hrs, "Equipment out of service, please do not use under any circumstances - equipment name and number "handrail" Problem reported, Do not use as loose". June 19, 2012, Inspector interviewed a staff member from the maintenance department who reported that the handrail; reported in a state of disrepair on June 4, 2012 at 0040 hrs, had not been repaired because there was no concrete available at the home and that their boss had not supplied any. Inspector noted that the handrail was repaired on June 20, 2012.

June 18, 2012 Inspector observed the wall guard/baseboard in a 3rd floor resident room was significantly damaged and in need of repair.

June 19, 2012 Inspector made the following observations of the 2nd Floor balcony: the seams of outdoor carpeting were splitting in several areas and the carpet surface is uneven in several areas posing a tripping hazard. Moss is growing along front railing and along the columns located beside the windows. Inspector observed a vent protruding approximately 6-7 inches from the balcony floor posing a tripping hazard.

June 19, 2012, ESM was unable to describe what processes or procedures were in place in regards to the maintenance and housekeeping programs other than identifying the HIPPO Software. ESM was unable to describe the systems or processes regarding the housekeeping program and stated, "What processes are here? I can't answer that 100%, I was thrown into this position 3 weeks ago". ESM is currently working half days between 2 LTC homes and explained that their predecessor left on 2 days notice. The ESM will begin working full time in early July.

During the initial tour of the home on June 11, 2012, Inspector 106 noted that the whirlpool tub located in the 5th floor spa room was in a state of disrepair, staff were aware and a pink maintenance requisition was affixed to the side of the tub. On June 19, 2012 Inspector 122 noted that the whirlpool tub remained in a state of disrepair and as the Inspector awaited the arrival of the elevator, Inspector 122 observed a contractor arrive on the unit to repair the tub. June 19, 2012, the ESM reported that the home's contractor, did not have a local repairman and the home was experiencing difficulty in procuring services from the provider in Thunder Bay, ON.

June 21, 2012 at 16:06 hrs, Inspector observed the painted wooden trim, located on the lobby area and throughout the main level of the home was chipped. Flooring located in front entry of the home and council room is grossly worn.

June 21, 2012 at 10:25 hrs Inspector observed the flooring separating at seams near windows in 5th floor TV area. Walls of nursing station and under desk area in need of repair.

June 21, 2012, the ESM reported that in regards to the current state of the refurbished nursing stations, the walls between the upper and lower cabinets which were left in a state of disrepair following the installation of new cupboards, will be fitted with corkboard. ESM reported that the exposed wires and cables observed under the desk area of the refurbished nursing stations will be enclosed in an accessible manner. The ESM was unable to provide a timeframe for completion for either project. Inspector discussed the general state of disrepair at the home with the ESM who stated "I was warned about this before I took the position". The ESM also reported that he was having difficulty sorting through the previous ESM's records and locating documents. ESM commented that the home had been without an ESM for two years prior to his predecessor.

June 11, 2012, Inspector observed in the spa room on the 6th floor, the towel cupboard base is in disrepair with paint peeling and the baseboard heater has a piece of loose metal. (196)

The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [LTCHA 2007, S. O., c. 8, s. 15 (2) c]. (122)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board   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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 15th day of October, 2012

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : ROSE-MARIE FARWELL

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