Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 22, 2015	2015_269597_0003	S-000728-15	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

BEVERLEY GELLERT (597), DEBBIE WARPULA (577), LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 9, 10, 11, 12, 13, 16, 17, 18, 19 and 20, 2015

Additional logs completed concurrently with the RQI:
S-000545-14
S-000559-14
S-000271-14
S-000327-14
S-000496-14
S-000242-14
S-000241-14
S-000240-14
S-000239-14
S-000238-14
S-000181-14
S–000749-15
S-000750-15

During the course of the inspection, the inspector(s) spoke with The Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), RAI Coordinator, Social Worker, Maintenance Worker, Dietary Aides, Food Services Manager.

The inspectors also completed observations of residents and resident care, reviewed health care records and interviewed residents and their families.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
23 WN(s)
8 VPC(s)
11 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
O.Reg 79/10 s. 73. (1)	CO #005	2014_246196_0006	196

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Assessment data for resident #021 was reviewed from the date of admission to present. The initial assessment indicated the resident's continence status and whether they required any continence products. The following assessment indicated that the resident's

continence had deteriorated. The next two assessments reported the resident's continence status and requirements.

The current plan of care for resident #021 was reviewed by the inspector and it did not contain consistent information regarding the resident's continence.

S-#200, #201 and #202 were interviewed and they did not provide consistent descriptions of the resident's continence needs or requirements. S-#200, #201 and #202 reported that they have access to the care plan binder on each floor that contains the most current care plan.

The care plan for resident #021 did not provide clear direction to staff regarding continence and the use of continence products. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

The health record of resident #026 was reviewed by Inspector #597 and it was noted that the resident was discharged from a consultant early in 2014. The next two plan of care updates following indicated that the resident continued to be followed by this service.

The home did not update the plan of care to reflect that the resident was not followed by this consultant. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Inspector #597 reviewed the current plan of care for resident #024. Under the focus of high fall risk, the interventions listed were not consistent. The physician's order indicated that the resident required a restraining device.

The resident was observed up in their wheelchair with an alarm in place. S-#231 and S-#232 were interviewed and reported that the resident has an alarm in place and the resident is able to undo the device without assistance.

The physician order for the device was reviewed with S-#202. They confirmed that the order indicated that a restraining device in use for resident #024.

The plan of care for resident #024 did not provide clear instructions regarding the interventions in place to ensure resident safety. [s. 6. (1) (c)]

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

Resident #002 was observed to have bed rails elevated. The resident's current plan of care did not indicate the use of bed rails.

The plan of care for resident #002 did not provide clear instructions regarding the interventions in place to ensure resident safety. [s. 6. (1) (c)]

5. The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s.6 (2).

Resident #015 was observed to have natural teeth. The current plan of care noted that the resident "has no teeth or dentures". An interview with S-#208 identified that resident #015 had a couple of teeth. S-#213 reported that the resident has a few upper and lower teeth and S-#214 reported that the resident has no teeth or dentures.

Resident #015's plan of care was not based on an assessment of the resident and the needs of the resident. [s. 6. (2)]

6. The licensee has failed to 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).

The current care plan for resident #015, indicated that the call bell and light pull cords were to be within easy reach and in a consistent location.

The resident was observed during the inspection and on two occasions the call bell was out of reach of the resident and lying on the floor beside the bed. [s. 6. (7)]

7. 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. 2007, c. 8, s.6 (7).

The health care record for resident #027 was reviewed. The current care plan identified

the intervention of "RPN to take resident downstairs to administer medication before meals and then notify dietary staff so the resident's meal can be served."

The administration history for resident #027's indicated that the medication was administered 44 minutes before the meal was served.

S-#227 was questioned about being notified that this resident was seated in the dining room and it was reported that they had not been advised that the resident was seated, adding that sometimes the nursing staff advise but not today.

Resident #027 was not administered their medication as per the care plan, nor were they provided with a meal upon coming to the dining room. [s. 6. (7)]

8. The licensee has 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. 2007, c. 8, s.6 (10) (b).

The health care record for resident #015 was reviewed for information regarding nutrition. The current care plan indicated a nursing focus of high nutritional risk and included interventions to improve quality of life.

S-#230 was interviewed regarding resident #015 by Inspector #196 and they reported that the recommended interventions were not in place due to a change in medical condition.

The care plan for resident #015 was not updated to identify this change in resident status. [s. 6. (10) (b)]

9. The licensee has failed to ensure that the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective and different approaches have been considered in the revision of the plan of care. 2007, c. 8, s.6 (11)(b).

Resident #026 was followed by a consultant for a few months after admission to the home. The resident was discharged from the consultant as the home was able to effectively manage the resident's care.

Inspector #597 reviewed the progress notes for resident #026 which indicated that after their discharge from the consultant, the care was effectively managed for a period of time however the care needs began to increase until the resident required hospitalization.

The plan of care in effect for this resident during this time period was provided to the inspector by S-#205. There were no changes in the care plan to reflect the changing care needs that were noted in the progress notes.

The physician orders for resident #026 were reviewed. There were no changes to medications or treatments noted during this period of increasing care needs.

The home did not revise the plan of care for resident #026 when the care set out in the plan was not effective to manage their care needs. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 001, 002, 003, 004, 011 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The Licensee had failed to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

The progress notes for resident #026 were reviewed by Inspector #597 and it was documented that a PSW observed resident #075 inappropriately touching resident #026 on two different occasions in early 2014. The progress notes also indicate that resident #075 was also observed displaying sexual behaviors toward resident #026.

A few months later, staff have documented that they witnessed resident #075 inappropriately touching resident #026. The progress note entries for these incidents indicated that incident reports were completed by staff. The DOC was interviewed regarding the incidents as reported in the progress notes. The DOC was not able to provide copies of the incident reports, additional information or investigative notes.

The home failed to ensure that resident #026 was protected from abuse by resident #075. [s. 19.]

2. The licensee has failed to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

A Critical Incident report was submitted to the Director, for alleged abuse of resident #005 by a staff member. The report outlined an incident in which S-#215 walked into resident #005's room and verbally abused the resident.

S-#213 was assisting #005 with care and witnessed the incident. The report indicates that the home could not confirm evidence of abuse, and documented that resident did not consider the statement made by S-#215 to be malicious.

Inspector #577 reviewed the investigative notes. The notes indicate that the ED interviewed resident #005. The resident's responses to the interview questions indicated that the resident did not consider statement made by S-#215 to be malicious.

The inspector reviewed interview notes pertaining to statements made by witness S-#213 . These notes indicated that they witnessed the derogatory remark and that the resident was upset after the comment was made. They further indicated that the resident felt bad that they cannot be more independent and are now are reluctant to ask for assistance.

The inspector spoke with the Director of Care (DOC), who reported that incident wasn't reported as abuse because S-#215 stated they have a bantering, joking relationship with resident and the resident had confirmed that they didn't feel it was abuse.

The inspector spoke with resident #005, who reports they do not recall incident.

S-#213 was interviewed and reported that they felt the remark made towards resident

was inappropriate and not said in a joking manner. It was further reported that resident was upset, in tears, and told them that they did not like the comment. They also reported that the resident performed care without assistance and said they didn't want to be a bother.

A record review of the employee file for S-#215 was conducted. The records indicated that this staff had previously received verbal discipline and two separate suspensions for resident neglect.

The home did not ensure that resident #005 was protected from abuse by S-#215. [s. 19. (1)]

3. The licensee has failed to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

A staff member, S-#228 was overheard by Inspectors #196, #597 and #577 using a loud tone of voice and stating to resident #016, "If you keep yelling, I'm not helping you", when they had asked for assistance. Inspector #196 questioned the staff member and they reported that this resident was yelling and asking for assistance now and that they were the only staff on the unit for the previous twenty minutes as the other PSW was in the dining room and the RPN was on a break. They also reported that the resident requires two staff to assist with care and stated that it is "too hard to get someone to come to help from another floor".

The employee file for staff member S-#228 was reviewed and included an email from another staff member to the DOC, outlining a separate incident in which S-#228 was alleged to have not provided care to a different resident. An interview was conducted with the DOC, and it was reported that no investigation was done about the incident specified in the email.

The home did not ensure that resident #016 was protected from abuse by S-#228. [s. 19. (1)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. 2007 c. 8, s. 24 (1), 195 (2).

The progress notes for resident #026 were reviewed by Inspector #597 and it was documented that a PSW observed resident #075 inappropriately touching resident #026. Another progress note indicated that resident #026 was observed in the resident lounge with resident #075 who was in appropriately touching resident #026. Later that same day, the resident #075 was found by staff displaying inappropriate sexual behaviours towards resident #026.

Staff have documented that they witnessed resident #075 inappropriately touching resident #026 in the dining room a few months later.

The DOC was unable to provide incident reports or investigation notes from any of the four incidents of inappropriate touching and confirmed that the incidents were not reported to the Director. [s. 24. (1)]

2. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. 2007 c. 8, s. 24 (1), 195 (2).

Inspector #577 found a letter of suspension to S-#215 for resident neglect, during a record review of employee's file.   The inspector spoke with the DOC and they reported that this incident of resident neglect was not reported to the Director. [s. 24. (1)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

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

Specifically failed to comply with the following:

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. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
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; O. Reg. 363/11, s. 1 (1, 2).

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways and 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 must be, kept closed and locked and equipped with a door access control system that is kept on at all times. O. Reg. 79/10 s. 9. (1).

A complaint was received by the Ministry of Health and Long Term Care in relation to the safety of residents who might be exit seeking within the home.

The progress notes for resident #026 were reviewed by Inspector #597. The progress notes indicated that resident #026 had been able to access a locked stairwell and exit the home on three occasions.

2. The licensee failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

During a tour of the third floor,Inspector #577 observed the laundry chute door tied with a rope in an open position. Inspector spoke with S-#217, who reported that door should always be locked. Inspector observed S-#217 lock the door. [s. 9. (1) 2.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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 O. Reg. 79/10, s. 129 (1).
(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 licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked. O. Reg 79/10, s. 129 (1).

During the inspection, two prescription topical medication containers were observed on the bedside table of resident #070. On resident #071's bedside table, there was a container of prescription topical medication. The Health Care Record for these two residents were reviewed by the inspector and physician's orders to keep these prescription topical creams at the bedside of the respective residents were not present. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg 79/10, s. 129 (1).

The narcotic bin in the bottom drawer of the medication cart was observed to be unlocked while the cart was unattended and stationed in the hallway outside the nursing station. The inspector located and confirmed with S-#216, that this drawer was to be double locked at all times. [s. 129. (1) (b)]

Additional Required Actions:

CO # - 008 will be 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. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents’ Council. O. Reg. 79/10, s. 73 (1).

Inspector #577 spoke with S-#221, who reported that the Resident Council has not reviewed meal and snack times. [s. 73. (1) 2.]

2. The licensee has failed to ensure that the home has a dining and snack service that includes a process to ensure that food service workers and other staff assisting residents are aware of the residents’ diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

During a dining observation, Inspector #577 found an outdated dietary binder on the beverage cart in the dining room. The binder contained an outdated list of all residents' diets, preferences and restrictions. Inspector spoke with S-#222 in the dining room, who reported that the dietary binder is not updated and showed the inspector a list of three residents in the binder that no longer resided in home. S-#218 also confirmed to the inspector that nursing staff refer to the dietary binder on the beverage cart, and reported that the binder is not updated. It was further reported by S-#223 that the dietary binder is not updated. The inspector spoke with S-#221, concerning the dietary binder in the dining room. They confirmed that it's not updated and reported that they were unaware there was a binder on the beverage cart.

The dietary binder on the beverage cart in the dining room contained outdated information regarding resident's diets, special needs and preferences. The information was not updated until the inspector brought it to the attention of S-#221. [s. 73. (1) 5.]

Additional Required Actions:

CO # - 009 will be 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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is, (a) an organized program of nursing services for the home to meet the assessed needs of the residents; and (b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8(1).

A resident was observed to request assistance with care by Inspector #196 and S-#228 reported to the inspector that they were the only staff on the unit for previous 20 minutes as the other PSW was in the dining room and had just come back now and the RPN was reported to be on break. Resident #016, required the assistance of two staff members. The current care plan was reviewed and included the intervention of two staff assist with transfers.

Inspector #196 interviewed the ED regarding staffing levels in the home.

The ED reported that it is the home's expectation to have two staff members at all times on the units for resident care and if assistance is required they can call the RPN or RN.

S-#229 confirmed that the home's expectation is that there are two staff on each floor at all times for resident care. The contingency plan for when staff call in sick or when working short is in place and the home will often take the "third" PSW from the second floor and assign to the floor that is short staffed. There are recreation and restorative care aides situated on the second floor to assist if required.

The home did not ensure that there were two staff available on the unit at all times as per the home's expectation reported by the ED and S-#229. [s. 8. (1)]

2. The licensee failed to ensure that there is, (a) an organized program of nursing services for the home to meet the assessed needs of the residents; and (b) an organized

program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8(1).

S-#209 was interviewed regarding staffing levels and resident care needs and they stated that there usually is one RPN and two PSWs working on that floor. This morning there is only one PSW from 0700 hrs - 1100 hrs because another area was short and the second PSW was pulled to work in that area.

The staff reported that this morning in order to accommodate coffee breaks - there was only one staff on the floor for two 15 minute periods.

S-#209 stated that if they needed to help a resident requiring two person assist that they would call another staff from another unit or go down the hall to the RN/RSW office for help. S-#209 confirmed that there are several residents on the second floor that require a two person assist with care.

The ED reported that it is the home's expectation is to have two staff members at all times on the units for resident care and if assistance is required they can call the RPN or RN.

S-#229 confirmed that the home's expectation is that there are two staff on each floor at all times for resident care. The contingency plan for when staff call in sick or when working short is in place and the home will often take the "third" PSW from the second floor and assign to the floor that is short staffed. There are recreation and restorative care staff situated on the second floor to assist if required.

The home did not ensure that there were two staff available on the unit at all times as reported by the ED and S-#229. [s. 8. (1)]

Additional Required Actions:

CO # - 010 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #8: 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:

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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to 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. 2007, c. 8, s. 3 (1).

Resident #003 reported to Inspector #577, that S-#218 had been rude to them. The resident reported an incident when they had requested that a female staff assist them. The resident further reported that S-#218 responded with an inappropriate, demeaning comment towards them.

Resident #002 reported to the inspector that some staff have been rude to them when they ask to go back to their bed after breakfast and when they request assistance to use bathroom. They specifically reported that staff will say, "No, not right now or I asked you 10 minutes ago and you said you didn't have to go to the washroom".

Resident #003 reported to inspector that they were in dining room for dinner one evening and a dietary worker was rude towards them. Specifically, the resident stated that the dietary worker said "You're early, go back to where you came from!" to them. The resident reported that they were so upset by the comment that they could not eat their dinner.

The home failed to ensure that resident #003 was treated with courtesy and respect. [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted and that 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, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with. O. Reg 79/10. s. 8. (1).

Resident #002 complained of pain during the stage one interview. Inspector #597 reviewed the annual care conference notes for resident #002 and the pharmacist's note indicated that the resident was complaining of frequent discomfort and the decision was made to order regular analgesic.

Inspector #597 interviewed S-#205 and they reported that this resident does not have any pain during their shift. They confirmed that the resident does receive analgesic regularly but they were not sure why this was ordered.

S-#208 was interviewed and they confirmed that an electronic pain assessment is completed on admission to the home and the home uses a paper pain monitoring sheet to assess pain issues that arise. If the pain is not managed then an electronic pain assessment would be triggered on the next quarterly assessment.

This monitoring sheet was not initiated for resident #002 until after the inspector had discussed pain assessment for resident #002 with S-#208.

Inspector #597 interviewed resident #002 and they reported that their pain has been present for approximately two months. The resident reported that the pain is not totally relieved with the pain medication that is ordered.

A new regular pain medication was scheduled for resident #002. The home did not ensure that a pain monitoring was initiated as per policy. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place for the pain program is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).

Inspector #577 spoke with the ADOC regarding bed rail assessments. The inspector was provided the home's policy, which indicated that all residents using side rails will be assessed for the need for side rails and the associated risk with the utilization of the side rail decision tree.

Resident #001 was observed to have two quarter bed rails elevated. The inspector spoke with S-#218 and S-#219, who reported that bed rails are used for resident #001 for re-positioning in bed and as assist rails to help with transferring. The inspector could not find a completed bed rail assessment for resident #001.

The home was unable to provide documentation of the completed bed rail assessment for resident #001. [s. 15. (1) (a)]

2. The licensee has failed to ensure that (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).

Resident #002 was observed to have two quarter bed rails elevated. The inspector spoke with S-#213, who reported that bed rails are used for resident #002 to prevent resident from rolling out of bed. S-#208 reported that bed rails are used for residents comfort and safety. The inspector could not find a completed bed rail assessment form for resident #002. The ADOC confirmed that a bed rail assessment was not completed for resident #002. [s. 15. (1) (a)]

3. The licensee has failed to ensure that (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).

Resident #003 was observed to have one quarter bed rail elevated. The inspector spoke with S-#218 and S-#219, who reported that one quarter bed rail is used for resident #003 for help with transferring. The inspector could not find a completed bed rail assessment for resident #003. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident,, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system is on at all times. O. Reg.79/10, s.17 (1) (b).

During Stage 1 of the inspection, the bedside call bells in two resident rooms, and one bathroom call bell were found not to be in working order by Inspectors #577 and #597. Staff were immediately advised that these bells were not in working order. Staff stated that maintenance would be contacted.

The bed side call bell in one room and the bathroom call bell were again found to be not in working order. Staff were advised immediately and maintenance was paged.

Inspector #597 interviewed S-#233 regarding repair of the call bells within the home. S-#233 reported that if bells are found not to be working during the day time hours, nursing staff would page maintenance. If the bells are found to be not working after hours then a Physical Plant Service Requisition would be completed and left in the Maintenance mailbox. [s. 17. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that is on at all times, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations; (b) appropriate action is taken in response to every such incident; and (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

A Critical Incident report was submitted to the Director by the DOC. The report described events, where the family of resident #006 arrived to the home and demanded resident's discharge due to resident reporting staff were rough with them while assisting them with their care. Family had reported that resident was complaining of pain. The resident was transported to acute care for investigation of pain, given a one week leave of absence to be with their family and then officially discharged from the home.

During the inspection, Inspector #577 spoke with the DOC, who reported that, despite the submission of the critical incident to the Director, an investigation based on resident and family's complaints of abuse was not conducted by the home. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident of abuse or neglect that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 8. Continence, including bladder and bowel elimination. O. Reg.79/10, s.26 (3)8.

The most recent assessment for resident #011 was reviewed for information regarding bowel and bladder continence. The assessment identified the resident continence status and needs regarding continence.

Resident #011 was observed by inspector #196, alone in their washroom, trying to wipe feces off the outside of their brief.

The current care plan was reviewed and did not include reference to continence, bladder or bowel elimination. [s. 26. (3) 8.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: continence, including bladder and bowel elimination, specifically in regards to resident #011, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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. 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. O. Reg. 79/10, s.33 (1).

A complaint had been received by the Director regarding residents not receiving baths as required.

The bath documentation for one month was reviewed for resident #024. It was documented that the resident received a total of six baths over the course of a month and not the minimum of eight, or twice weekly. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident 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, specifically to resident #024, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) each resident who is incontinent receives an

assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. O. Reg.79/10, s.51 (2) (a).

An admission continence assessment was completed on Resident #011's admission to the home and determined the resident's continence status. The assessment completed by day 14, post admission, for this same resident, identified that the resident's continence status and needs were actually different than what was determined on admission.

The health care records for resident #011 were reviewed for a continence assessment using a clinically appropriate assessment instrument completed after the determination that the resident's continence needs were different that assessed on admission. No assessment was located. An interview was conducted with S-#220 and it was reported that the resident's continence status is different than assessed on admission and that a continence assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of continence is done on admission, but not aware of any other times it is done. [s. 51. (2) (a)]

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

Assessment data for resident #021 was reviewed from the date of admission to present. The assessment indicated the resident's continence status and requirements. The following assessment indicated that the resident's continence had deteriorated. The next two assessments reported that the continence status and requirements had changed.

The current plan of care for resident #021 contained inconsistent information regarding continence.

Inspector #597 requested that S-#204 provide all continence assessments for resident #021 for review. The admission assessment was provided to inspector.

The paper health care record for resident #021 was reviewed and Inspector #597 was unable to locate a paper copy of continence assessment.

Staff #202 was interviewed regarding the continence of resident #021. Staff reported that they are not aware that a continence assessment has been completed for resident #021. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to 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, specifically to resident's #021 and #011, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident’s care is held within six weeks following the resident’s admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident’s substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that (c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Inspector #577 reviewed the 'Care Conference Review' for resident #004. This record did not list persons in attendance of the care conference or the results of the conference.

S-#210 was interviewed regarding resident care conferences. This staff confirmed that a care conference for resident #004 was held but was unable to provide documentation that indicated the participant names or the results of the conference. [s. 27. (1)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, (a) mouth care in the morning and evening, including the cleaning of dentures; (b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and (c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident’s substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

During an interview, resident #001 reported to the inspector that their dentures and mouth are cleaned once daily.

Inspector #577 reviewed resident's most recent care plan which indicated that the resident 'requires support for oral hygiene and staff are to clean and manage residents dentures'.

The inspector spoke with S-#224 and the ADOC, who both reported that residents aren't offered annual dental assessments.

The home did not ensure that twice daily mouth care including the cleaning of dentures and the offer of annual dental assessments was provided to resident #001. [s. 34. (1) (a)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies are developed and implemented to meet the needs of those residents with compromised communication and verbalization skills, residents with cognitive impairment and residents who cannot communicate in the languages used in the home. O. Reg.79/10, s. 43.

Inspector #597 reviewed the annual medical form for resident #023 that indicated that the resident had a language barrier.

Inspector #616 interviewed S-#206 regarding the language barrier of resident #023. Staff reported that they do not use a communication tool with resident but they have worked with them long enough that they know what the resident wants. They also reported that resident #023's usual response is "yes".

Inspector #597 interviewed S-#209 and S-#207 and S-#209 reported that the resident understands English but does not speak English other than yes or no answers and is generally very quiet. They also reported that the resident will cry out if in pain and then staff will initiate yes / no questioning until they figure out what is wrong. No translation tools are in use for this resident, however S-#209 has seen them used for other residents. They also think that there might be some residents or staff that can translate but are not aware if there is a list of translators available.

S-#207 reported that they rarely work with resident #023, but they are aware that the resident understands English but will only verbalize yes and no. S-#207 reported that they have seen communication tools used for other residents in the home but not for this resident.

S-#208 was interviewed and reported that the resident communicates well in their own language with family and friends.

Inspector #597 interviewed S-#210 regarding the strategies in place in the home to assist with residents who have language barriers. S-#210 reported that a volunteer visits one time per week to visit with residents. If care issues are addressed during the visit, S-#210 will record in the progress notes. This volunteer will also help the recreation staff to assess interests on admission. It was reported that this service has been in place for approximately two months and they have not yet established a referral process. It was reported that other resources that have been used include family members, an evening staff worker and translators via the Multicultural Centre. S-#211 reported to the inspector that the home does arrange cultural event’s with some community partners.

The current care plan for resident #023 identifies a nursing focus of communication alteration as evidenced by problem making self understood and problem understanding others. The interventions listed include obtaining the resident's attention before beginning to speak to them, approach resident from the front, provide reassurance and

patience when communicating with resident and ask yes or no questions if appropriate. The care plan does not address strategies that will assist the resident in making themselves understood such as the use of communication tools or translation. [s. 43.]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (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).

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

Findings/Faits saillants :

The licensee has failed to ensure that the advice of the Family Council is sought in developing and carrying out the satisfaction survey, and in acting on its results. 2007, c. 8, s. 85 (3).

Inspector #597 interviewed the president of the Family Council who reported that the Family Council membership has not had the opportunity to advise in the development and carrying out of the satisfaction survey or in acting on its results.

The Executive Director was interviewed and confirmed that the Family Council has not yet been given the opportunity to provide advice on the development or carrying out of the satisfaction survey or acting on its results. [s. 85. (3)]

2. The licensee has failed to ensure that the satisfaction survey results have been made available to the Family Council in order to seek the advice of the Council about the survey. 2007, c. 8, s. 85 (4)(a).

The assistant to the Family Council, S-#210, and reported that although the survey results have been made available to the Family Council, the results have not been officially reviewed or discussed with the members of the Family Council.

The president of the Family Council was also interviewed and they reported that they do not recall the results of the survey being presented or discussed at the Family Council meetings.

Family Council meeting minutes for the last three meetings were provided to the inspector. The meeting minutes indicate that discussion regarding satisfaction surveys had been deferred. [s.85.(4)(a)] (597)

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint. O. Reg.79/10, s.101 (1).

During Stage 1 interviews resident #021 and their daughter reported to Inspector #597 that a few days after the resident was admitted to the home, personal items were stolen from their room. It was also reported that the disappearance was reported to staff and the articles were not returned. The resident and their family were not aware of the results of the investigation.

Inspector #597 interviewed the Executive Director (ED). The ED reported that the home has a policy that addressed the management of concerns, complaints and compliments. The complaint management program binder was reviewed and the inspector was not able to find a record of the investigation into the disappearance of resident #021's property. [s. 101. (1) 1.]

2. The licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, that the person who made the complaint has received a response indicating what the licensee has done to resolve the complaint or that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg.79/10, s.101 (1)3.

During Stage 1 interviews resident #021 and their daughter reported to Inspector #597 that a few days after the resident was admitted to the home, personal property was stolen from their room. It was also reported that the disappearance was reported to staff and the articles were not returned. The resident and their family were not aware of the results of the investigation.

Inspector #597 interviewed the Executive Director (ED). The ED reported that the home has a policy that addressed the management of concerns, complaints and compliments. The complaint management program binder was reviewed and the inspector was not able to find a record of the investigation into the disappearance of resident #021's property.

The home's policy to manage concerns and complaints was reviewed by Inspector #597. The policy states that the individual who is first aware of the verbal concern or complaint will initiate the Client Service Response (CSR) form and forward to the Executive Director. The CSR form will be completed in full and all actions taken will be documented and the form filed in the complaints management binder. Upon completion of an investigation of the concerns, a response will be provided to indicate what has been done to resolve the complaint, or, if the complaint is found to be unfounded, an explanation will provided regarding this finding.

The home failed to investigate the disappearance of resident #021's belongings and respond to the complainant. [s. 101. (1) 3.]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: 2. A description of the individuals involved in the incident, including, i. names of all residents involved in the incident, ii. names of any staff members or other persons who were present at or discovered the incident. O. Reg.79/10, s.104 (1)2.

A CIS report was submitted to the Director outlining an incident of witnessed verbal abuse from a staff member towards a resident of the home and the report did not include the name of the staff member. [s. 104. (1) 2.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents are communicated to the Family Council. O. Reg.79/10, s.228.

The president of the Family Council was interviewed by Inspector #597. The president reported that they are not aware of the details of the quality improvement plan that is established in the home.

The assistant to the Family Council was interviewed by Inspector #597. They reported that the Family Council has been in place for less than a year and has been working on Mission Statement and Terms of Reference. The Family Council has not yet been presented with any details of the quality improvement plan of the home. [s. 228. 3.]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During the inspection, Inspector #196 observed an unlabelled, white coloured soiled comb and one pink coloured soiled hairbrush, in a common tub room. An interview was conducted with S-#218 and they reported that they did not know who's comb and hairbrush they were and stated they shouldn't be in here. [s. 229. (4)]

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

Inspector #577 observed numerous used nail files and hair combs stored in a plastic bin on a shelf in a spa room. Two hair combs that were on the top of pile were unclean with strands of hair on them. The inspector spoke with S-#203, who confirmed that these hair combs appear used, unclean, and are supposed to be clean and not used.

Inspector #577 observed a used, unlabelled blue plastic bed pan hanging on a hook on the wall in a shared bathroom. Inspector spoke with S-#218 and #225 concerning labelling resident’s bedpans and urinals. Both reported that they do not label bedpans and urinals with resident’s names. S-#218 reported that the process to clean used bed pans includes emptying contents into hopper, cleaning item with disinfectant spray and returning bed pan to bathroom. They also reported that after cleaning, it could be used on either resident.

The inspector spoke with the S-#226, who reported that urinals and bedpans in shared bathrooms are not labelled. It was further reported that it would be common knowledge between staff as to which resident needs the bedpan and/or urinal. S-#226 also reported that there isn't a specific policy concerning labelling urinals and bedpans for residents. [s. 229. (4)]

Issued on this 1st day of June, 2015

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

Original report signed by the inspector.

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) :	BEVERLEY GELLERT (597), DEBBIE WARPULA (577), LAUREN TENHUNEN (196)
Inspection No. / No de l'inspection :	2015_269597_0003
Log No. / Registre no:	S-000728-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 22, 2015
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 :	Jonathon Riabov

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

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_269597_0008, CO #001; 2014_269597_0008, CO #002;

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 :

Every licensee of a long-term care home shall ensure that there is a written plan of care for residents #002, #021, #024 and #026 and all other residents, that sets out clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Grounds / Motifs :

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

Resident #002 was observed to have bed rails elevated. The resident's current plan of care did not indicate the use of bed rails.

The plan of care for resident #002 did not provide clear instructions regarding the interventions in place to ensure resident safety. [s. 6. (1) (c)]
(577)

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Inspector #597 reviewed the current plan of care for resident #024. Under the focus of high fall risk, the interventions listed were not consistent. The

physician's order indicated that the resident required a restraining device.

The resident was observed up in their wheelchair with an alarm in place. S-#231 and S-#232 were interviewed and reported that the resident has an alarm in place and the resident is able to undo the device without assistance.

The physician order for the device was reviewed with S-#202. They confirmed that the order indicated that a restraining device in use for resident #024.

The plan of care for resident #024 did not provide clear instructions regarding the interventions in place to ensure resident safety. [s. 6. (1) (c)] (597)

3. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

The health record of resident #026 was reviewed by Inspector #597 and it was noted that the resident was discharged from a consultant early in 2014. The next two plan of care updates following indicated that the resident continued to be followed by this service.

The home did not update the plan of care to reflect that the resident was not followed by this consultant. [s. 6. (1) (c)] (597)

4. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Assessment data for resident #021 was reviewed from the date of admission to present. The initial assessment indicated the resident's continence status and whether they required any continence products. The following assessment indicated that the resident's continence had deteriorated. The next two assessments reported the resident's continence status and requirements.

The current plan of care for resident #021 was reviewed by the inspector and it did not contain consistent information regarding the resident's continence.

S-#200, #201 and #202 were interviewed and they did not provide consistent descriptions of the resident's continence needs or requirements. S-#200, #201 and #202 reported that they have access to the care plan binder on each floor that contains the most current care plan.

The care plan for resident #021 did not provide clear direction to staff regarding continence and the use of continence products. [s. 6. (1) (c)] (597)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 19, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care for resident #015 all other residents is based on an assessment of the residents and their needs and preferences. 2007, c. 8, s. 6 (2).

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s.6 (2).

Resident #015 was observed to have natural teeth. The current plan of care noted that the resident "has no teeth or dentures". An interview with S-#208 identified that resident #015 had a couple of teeth. S-#213 reported that the resident has a few upper and lower teeth and S-#214 reported that the resident has no teeth or dentures.

Resident #015's plan of care was not based on an assessment of the resident and the needs of the resident. [s. 6. (2)] (196)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 19, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The licensee shall ensure that resident #026 and all other residents are being reassessed, the plan of care is being revised because care set out in the plan has not been effective and that different approaches have been considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Grounds / Motifs :

1. The licensee has failed to ensure that the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective and different approaches have been considered in the revision of the plan of care. 2007, c. 8, s.6 (11)(b).

Resident #026 was followed by a consultant for a few months after admission to the home. The resident was discharged from the consultant as the home was able to effectively manage the resident's care.

Inspector #597 reviewed the progress notes for resident #026 which indicated that after their discharge from the consultant, the care was effectively managed for a period of time however the care needs began to increase until the resident required hospitalization.

The plan of care in effect for this resident during this time period was provided to the inspector by S-#205. There were no changes in the care plan to reflect the changing care needs that were noted in the progress notes.

The physician orders for resident #026 were reviewed. There were no changes to medications or treatments noted during this period of increasing care needs.

The home did not revise the plan of care for resident #026 when the care set out in the plan was not effective to manage their care needs. [s. 6. (11) (b)]
(597)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 19, 2015

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_246196_0006, CO #001;

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 the care set out in the plan of care for residents #015 and #027 and all other residents is provided to the residents as specified in the plan. 2007, c. 8, s. 6 (7).

Grounds / Motifs :

1. 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. 2007, c. 8, s. 6 (7).

A written notification / voluntary plan of correction (WN / VPC) was issued on August 7, 2014, related to LTCHA 2007, c. 8., s. 6 (7).

A compliance order (CO) was issued on May 29, 2014, for non compliance related to LTCHA 2007, c. 8., s. 6 (7).

A compliance order (CO) was issued on June 5, 2013, for non compliance related to LTCHA 2007, c. 8., s. 6 (7).

The health care record for resident #027 was reviewed. The current care plan identified the intervention of "RPN to take resident downstairs to administer medication before meals and then notify dietary staff so the resident's meal can be served."

The administration history for resident #027's indicated that the medication was administered 44 minutes before the meal was served.

S-#227 was questioned about being notified that this resident was seated in the dining room and it was reported that they had not been advised that the resident was seated, adding that sometimes the nursing staff advise but not today.

Resident #027 was not administered their medication as per the care plan, nor were they provided with a meal upon coming to the dining room. [s. 6. (7)] (196)

2. The licensee has failed to 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).

The current care plan for resident #015, indicated that the call bell and light pull cords were to be within easy reach and in a consistent location.

The resident was observed during the inspection and on two occasions the call bell was out of reach of the resident and lying on the floor beside the bed. [s. 6. (7)] (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 19, 2015

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Order / Ordre :

The Licensee shall prepare, submit and implement a plan for achieving compliance under s. 19 (1) of the LTCHA. The plan is to include:

(1) What interventions will be implemented to monitor resident #075 to ensure that other residents are protected from abuse.

(2) Strategies to manage resident #075 abusive behaviors, considering psychological, pharmaceutical, behavioral and physical interventions. Resident responses are to be documented.

(3) Strategies to protect other residents, especially those who wander, from resident #075.

(4) A process to ensure that all matters as detailed in LTCHA, 2007, c. 8. s 24 (1), 195 (2) are immediately reported to the Director and investigated.

This plan must be faxed, to the attention of LTCH Inspector Bev Gellert, at (705) 564-3133. The plan is due on June 5, 2015, with a compliance date of June 19, 2015.

Grounds / Motifs :

1. The Licensee had failed to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

The progress notes for resident #026 were reviewed by Inspector #597 and it was documented that a PSW observed resident #075 inappropriately touching resident #026 on two different occasions in early 2014. The progress notes also indicate that resident #075 was also observed displaying sexual behaviors

toward resident #026.

A few months later, staff have documented that they witnessed resident #075 inappropriately touching resident #026. The progress note entries for these incidents indicated that incident reports were completed by staff. The DOC was interviewed regarding the incidents as reported in the progress notes. The DOC was not able to provide copies of the incident reports, additional information or investigative notes.

The home failed to ensure that resident #026 was protected from abuse by resident #075. [s. 19.] (597)

2. The licensee has failed to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

A staff member, S-#228 was overheard by Inspectors #196, #597 and #577 using a loud tone of voice and stating to resident #016, "If you keep yelling, I'm not helping you", when they had asked for assistance. Inspector #196 questioned the staff member and they reported that this resident was yelling and asking for assistance and that they were the only staff on the unit for the previous twenty minutes as the other PSW was in the dining room and the RPN was on a break. They also reported that the resident requires two staff to assist with care and stated that it is "too hard to get someone to come to help from another floor".

The employee file for staff member S-#228 was reviewed and included an email from another staff member to the DOC, outlining a separate incident in which S-#228 was alleged to have not provided care to a different resident. An interview was conducted with the DOC, and it was reported that no investigation was done about the incident specified in the email.

The home did not ensure that resident #016 was protected from abuse by S-#228. [s. 19. (1)]
(196)

3. The licensee has failed to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

A Critical Incident report was submitted to the Director for alleged abuse of resident #005 by a staff member. The report outlined an incident in which S-#215 walked into resident #005's room and verbally abused the resident.

S-#213 was assisting #005 with care and witnessed the incident. The report indicates that the home could not confirm evidence of abuse, and documented that resident did not consider the statement made by S-#215 to be malicious.

Inspector #577 reviewed the investigative notes. The notes indicate that the ED interviewed resident #005. The resident's responses to the interview questions indicated that the resident did not consider statement made by S-#215 to be malicious.

The inspector reviewed interview notes pertaining to statements made by witness S-#213. These notes indicated that they witnessed the derogatory remark and that the resident was upset after the comment was made. They further indicated that the resident felt bad that they cannot be more independent and are now are reluctant to ask for assistance.

The inspector spoke with the Director of Care (DOC), who reported that incident wasn't reported as abuse because S-#215 stated they have a bantering, joking relationship with resident and the resident had confirmed that they didn't feel it was abuse.

The inspector spoke with resident #005, who reports they do not recall incident.

S-#213 was interviewed and reported that they felt the remark made towards resident was inappropriate and not said in a joking manner. It was further reported that resident was upset, in tears, and told them that they did not like the comment. They also reported that the resident performed care without assistance and said they didn't want to be a bother.

A record review of the employee file for S-#215 was conducted. The records indicated that this staff had previously received verbal discipline and two separate suspensions for resident neglect.

The home did not ensure that resident #005 was protected from abuse by S-#215. [s. 19. (1)]

(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 19, 2015

Order # / Ordre no : 006 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_246196_0006, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee shall ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. c. 8, s. 24 (1), 195 (2).

Grounds / Motifs :

1. A Compliance Order, specific to LTCHA 2007, c.8, s.24(1) had been issued previously on June 8, 2012.

A Compliance Order, specific to LTCHA 2007, c.8, s.24(1) had been issued previously on May 29, 2014.
(577)

2. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was

based to the Director. 2007 c. 8, s. 24 (1), 195 (2).

Compliance Orders (CO) for non compliance related to LTCHA 2007, c.8, s.24 (1) had been issued previously on June 8, 2012, and May 29, 2014.

Inspector #577 found a letter of suspension to S-#215 for resident neglect, during a record review of employee's file. The inspector spoke with the DOC and they reported that this incident of resident neglect was not reported to the Director. [s. 24. (1)]
(577)

3. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. 2007 c. 8, s. 24 (1), 195 (2).

The progress notes for resident #026 were reviewed by Inspector #597 and it was documented that a PSW observed resident #075 inappropriately touching resident #026. Another progress note indicated that resident #026 was observed in the resident lounge with resident #075 who was in appropriately touching resident #026. Later that same day, the resident #075 was found by staff displaying inappropriate sexual behaviours towards resident #026.

Staff have documented that they witnessed resident #075 inappropriately touching resident #026 in the dining room a few months later.

The DOC was unable to provide incident reports or investigation notes from any of the four incidents of inappropriate touching and confirmed that the incidents were not reported to the Director. [s. 24. (1)]
(597)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 05, 2015

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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, and those doors must be kept closed and locked when they are not being supervised by staff.
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; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee shall ensure that all doors leading to stairways and 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 must be,
kept closed and locked and equipped with a door access control system that is kept on at all times and all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9 (1).

Grounds / Motifs :

1. The licensee has failed to ensure that all doors leading to stairways and 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 must be, kept closed and locked and equipped with a door access control system that is kept on at all times. O. Reg. 79/10 s. 9. (1).

A complaint was received by the Ministry of Health and Long Term Care in relation to the safety of residents who might be exit seeking within the home.

The progress notes for resident #026 were reviewed by Inspector #597. The progress notes indicated that resident #026 had been able to access a locked stairwell and exit the home on three occasions. [r.9 (1)] (597)

2. The licensee failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

During a tour of the third floor,Inspector #577 observed the laundry chute door tied with a rope in an open position. Inspector spoke with S-#217, who reported that door should always be locked. Inspector observed S-#217 lock the door. [s. 9. (1) 2.] (577)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 05, 2015

Order # / Ordre no : 008 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_246196_0006, CO #004;

Pursuant to / Aux termes de :

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

Order / Ordre :

Every licensee of a long-term care home shall ensure that drugs are stored in an area or a medication cart that is secure and locked. O. Reg. 79/10, s. 129 (1).

Grounds / Motifs :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked. O. Reg 79/10, s. 129 (1).

During the inspection, two prescription topical medication containers were observed on the bedside table of resident #070. On resident #071's bedside table, there was a container of prescription topical medication. The Health Care Record for these two residents were reviewed by the inspector and physician's orders to keep these prescription topical creams at the bedside of the respective residents were not present. [s. 129. (1) (a)]

(196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 29, 2015

Order # / Ordre no : 009

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

Pursuant to / Aux termes de :

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

Order / Ordre :

Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

Grounds / Motifs :

1. The licensee has failed to ensure that the home has a dining and snack service that includes a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

A voluntary plan of correction (VPC) was issued on August 7, 2014, for non compliance related to O. Reg. 79/10, s. 73 (1).

A previous compliance order (CO) was issued on May 29, 2014, for non compliance related to O. Reg. 79/10, s. 73 (1).

During a dining observation, Inspector #577 found an outdated dietary binder on the beverage cart in the dining room. The binder contained an outdated list of all residents' diets, preferences and restrictions. Inspector spoke with S-#222 in the dining room, who reported that the dietary binder is not updated and showed the inspector a list of three residents in the binder that no longer resided in home. S-#218 also confirmed to the inspector that nursing staff refer to the dietary binder on the beverage cart, and reported that the binder is not updated. It was further reported by S-#223 that the dietary binder is not updated. The inspector spoke with S-#221, concerning the dietary binder in the dining room. They confirmed that it's not updated and reported that they were unaware there was a binder on the beverage cart.

The dietary binder on the beverage cart in the dining room contained outdated information regarding resident's diets, special needs and preferences. The information was not updated until the inspector brought it to the attention of S-#221. [s. 73. (1) 5.] (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 05, 2015

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

Linked to Existing Order / Lien vers ordre existant: 2014_246196_0006, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Order / Ordre :

Every licensee of a long-term care home shall ensure that there is, (a) an organized program of nursing services for the home to meet the assessed needs of the residents; and (b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Grounds / Motifs :

1. The licensee failed to ensure that there is, (a) an organized program of nursing services for the home to meet the assessed needs of the residents; and (b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

A compliance order (CO) was issued on May 29, 2014 for non compliance related to LTCHA 2007, c. 8, s. 8 (1).

A resident was observed to request assistance with care by Inspector #196 and S-#228 reported to the inspector that they were the only staff on the unit for previous 20 minutes as the other PSW was in the dining room and had just come back now and the RPN was reported to be on break. Resident #016, required the assistance of two staff members. The current care plan was reviewed and included the intervention of two staff assist with transfers.

Inspector #196 interviewed the ED regarding staffing levels in the home.

The ED reported that it is the home's expectation to have two staff members at all times on the units for resident care and if assistance is required they can call the RPN or RN.

S-#229 confirmed that the home's expectation is that there are two staff on each floor at all times for resident care. The contingency plan for when staff call in sick or when working short is in place and the home will often take the "third" PSW from the second floor and assign to the floor that is short staffed. There are recreation and restorative care aides situated on the second floor to assist if required.

The home did not ensure that there were two staff available on the unit at all times as per the home's expectation reported by the ED and S-#229. [s. 8. (1)] (196)

2. The licensee failed to ensure that there is, (a) an organized program of nursing services for the home to meet the assessed needs of the residents; and (b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8(1).

S-#209 was interviewed regarding staffing levels and resident care needs and they stated that there usually is one RPN and two PSWs working on that floor. This morning there is only one PSW from 0700 hrs - 1100 hrs because another area was short and the second PSW was pulled to work in that area.

The staff reported that this morning in order to accommodate coffee breaks - there was only one staff on the floor for two 15 minute periods.

S-#209 stated that if they needed to help a resident requiring two person assist that they would call another staff from another unit or go down the hall to the RN/RSW office for help. S-#209 confirmed that there are several residents on the second floor that require a two person assist with care.

The ED reported that it is the home's expectation is to have two staff members at all times on the units for resident care and if assistance is required they can call the RPN or RN.

S-#229 confirmed that the home's expectation is that there are two staff on each floor at all times for resident care. The contingency plan for when staff call in sick or when working short is in place and the home will often take the "third" PSW from the second floor and assign to the floor that is short staffed. There are recreation and restorative care staff situated on the second floor to assist if required.

The home did not ensure that there were two staff available on the unit at all times as reported by the ED and S-#229. [s. 8. (1)] (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 19, 2015

Order # / Ordre no : 011

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 resident #015 and all other residents are 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. 2007, c. 8, s. 6 (10).

Grounds / Motifs :

1. The licensee has 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. 2007, c. 8, s. 6 (10).

Previous compliance orders (CO) were issued on January 23, 2014 and on June 5, 2013 for non compliance related to LTCHA 2007, c. 8., s. 6 (10) (b).

The health care record for resident #015 was reviewed for information regarding nutrition. The current care plan indicated a nursing focus of high nutritional risk and included interventions to improve quality of life.

S-#230 was interviewed regarding resident #015 by Inspector #196 and they reported that the recommended interventions were not in place due to a change in medical condition.

The care plan for resident #015 was not updated to identify this change in resident status. [s. 6. (10) (b)]

(196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 19, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 22nd day of May, 2015

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Beverley Gellert

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