Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROSE-MARIE FARWELL (122)
Inspection No. / No de l'inspection :	2013_224122_0001
Log No. / Registre no:	S-00001365-12
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jun 5, 2013
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	LAKEHEAD MANOR 135 SOUTH VICKERS STREET, THUNDER BAY, ON, P7E-1J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SHELEIGH MCMILLAN

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2012_053122_0014, CO #914;

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 is provided to residents #350, #250, #900 as specified in their plans. LTCHA 2007, S. O. 2007, c.8, s.6 (7)

Grounds / Motifs :

1. The plan of care for resident #350 contains goals focused on halting the resident's weight loss. Interventions contained in resident #350's dietary plan of care direct staff to encourage resident #350 to consume at least 75% of meals and document resident #350's food and fluid intake on the nutrition monitoring record. The Inspector reviewed the resident's nutrition monitoring record and noted that resident #350's food and fluid intake had not been recorded for the time period of March 1, 2013 to March 14, 2013.The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. LTCHA 2007, c. 8, s. 6 (7). (122)

2. On March 14, 2013 resident #250 was observed seated in a tilt wheelchair, which was parked in the hallway directly outside of the 3rd floor TV lounge. A wheelchair alarm was not observed on the wheelchair. The plan of care identifies a tilt wheelchair as resident #250's primary mode of locomotion. The plan of care directs staff to ensure the Velcro seat belt alarm is applied when resident #250 is seated in the wheelchair. The plan of care also identifies that resident #250 "prefers to watch TV in the TV lounge". The TV screen was not visible from where resident #250 was positioned in the hallway. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. LTCHA 2007, S. O. 2007, c.8, s. 6 (7 (122)

3. On March 14, 2013, resident #900 was observed seated in a wheelchair which was tilted backward at a 45 degree angle. The resident was slumped forward with their forehead nearly resting on both knees. Neither a seat belt nor chair alarm was applied to the resident. Resident #900's plan of care identifies a tilt wheelchair as the resident's primary mode of locomotion. The plan of care directs nursing staff to ensure the Posey alarm is in place and the two point front release seat belt is applied when resident #900 is seated in the wheelchair. Physiotherapy goals and interventions for resident #900 identify that the resident would benefit from repositioning to encourage extended positions and also recommend elevation of resident #900's head when the resident is in a seated position. The licensee failed to ensure the care set out in the plan of care was provided to the resident. LTCHA 2007, S. O., c.8, s. 6 (7). (122)

4. Providing residents with care as set out in the plan of care has been the subject of a previous Compliance Order (inspection 2012_053122_0014, CO #914, issued October 15, 2012 with a compliance date of March 9, 2013). (122)

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

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2012_053122_0014, CO #913;

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 residents #800, #700, #600 and #200 are reassessed and their plans 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. LTCHA 2007, S. O., c.8, s.6 (10) b

Grounds / Motifs :

1. Resident #800 was identified by staff as a cognitively impaired resident who receives 1:1 visitation due to their reluctance of participating in group activities. The plan of care identifies resident #800 is at risk of social isolation and decreased cognitive stimulation and identifies the resident's preference of talking and conversing with others. Resident #800's health care record was reviewed; however, the Inspector was unable to locate a recent recreation and social activity assessment. The Inspector interviewed staff #2000 who reported that assessments are completed upon admission only. Staff #2000 further reported that the recreation and social activity plans of care are updated through informal data gathering which utilize statistics or resident attendance rather than formal assessment tools or the resident's input. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs

change or care set out in the plan of care is no longer necessary. LTCHA 2007, S. O. 2007, c. 8, s. 6 (10) b (122)

2. Resident #700 was identified by staff as a cognitively impaired resident who receives 1:1 visitation due to the resident's reluctance of participating in group activities. The plan of care identifies resident #700 is at risk of social isolation and decreased cognitive stimulation and also identifies resident #700's preference of talking and visiting in her room 1:1. Resident #700's health care record was reviewed; however, the Inspector was unable to locate a recent recreation and social activity assessment. The Inspector interviewed staff #2000 who reported that assessments are completed upon admission only. Staff #2000 further reported that the recreation and social activity plans of care are updated through informal data gathering which utilize statistics or resident attendance rather than formal assessment tools or the resident's input. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan of care is no longer necessary. LTCHA 2007, S. O. 2007, c. 8, s. 6 (10) b (122)

3. Resident #600 was identified by staff as a cognitively impaired resident who receives 1:1 visitation due to their reluctance of participating in group activities. The plan of care identifies resident # 600 is at risk of social isolation and decreased cognitive stimulation and also identifies the resident's preference of talking and conversing 1:1. Resident #600's health care record was reviewed; however, the Inspector was unable to locate a recent recreation and social activity assessment. The Inspector interviewed staff #2000 who reported that assessments are completed upon admission only. Staff #2000 further reported that the recreation and social activity plans of care are updated through informal data gathering which utilize statistics or resident attendance rather than formal assessment tools or the resident's input. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan of care is no longer necessary. LTCHA 2007, S. O. 2007, c. 8, s. 6 (10) b (122)

4. Resident #200's plan of care identifies a tilt wheelchair as the resident's primary mode of locomotion. The plan of care directs staff to apply the Posey alarm and the 4 point positioning seat belt with side release buckle when the

resident is up in the wheelchair. On March 14, 2013, resident #200 was observed in the hallway seated in a wheelchair. A Posey alarm was not applied to the resident nor was one observed on the resident's wheelchair. The Inspector interviewed resident #200's family member in regards to resident's safety requirements when resident #200 is in the wheelchair. The family member reported that a Posey alarm had been applied in resident #200's previous wheelchair because the wheelchair was too large and caused resident #200 to slide out. The family member also reported that resident #200 has acquired a new wheelchair. Resident #200's new wheelchair is a better fit and as a result the Posey alarm is no longer required when the resident is seated in the wheelchair. The licensee failed to ensure that the resident's plan of care was reviewed and revised when the resident's care needs changed or when care set out in the plan of care was no longer necessary. LTCHA 2007, S. O., c.8, s.6 (10) b (122)

5. Reassessment of the resident, review and revision of the plan of care at least every six months has been the subject of a previous Compliance Order (inspection 2012_053122_0014, CO #913 issued October 15, 2012 with a compliance date of March 9, 2013). (122)

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

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. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according

to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure that resident #500 is treated with courtesy and respect in a way that fully recognizes the resident's individuality and respects the resident's dignity, specifically being provided privacy when staff provide care. LTCHA 2007, S.O. 2007, c.8, s. 3 (1) 1.

Grounds / Motifs :

1. On March 14, 2013 at 1350 hrs, the Inspector arrived on the 6th floor by way of the south end stairwell. Upon opening the stairwell door leading to the 6th floor hallway, the Inspector was able to see directly into room 602 and observe resident #500 lying on the bed facing the doorway. Resident #500 was naked from the waist down with genitals exposed while a staff member provided continence care to the resident. The licensee failed to ensure the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respect's the resident's dignity. LTCHA 2007, S. O. 2007, c.8, s. 3 (1) 1 (122)

2. The resident's right to be treated with courtesy and respect has been the subject of three previous written notifications and one voluntary plan of corrective action:

inspection #2011_106_1159_04, issued January 5, 2011
inspection # 2011_054133_0006, issued July 5, 2011
inspection #2012_053122_0014, issued October 15, 2012 (122)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 28, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
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.

Ontario

Ministry of Health and Long-Term Care

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

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

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 5th day of June, 2013

Signature of Inspector /
Signature de l'inspecteur : R. Farwell

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

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection 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 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 5, 2013	2013_224122_0001	S-00001365-12	Follow up

Licensee/Titulaire de permis

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

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

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

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

ROSE-MARIE FARWELL (122)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): March 13, 14, 15, 2013

This inspection was in follow up to three past due Compliance Orders and addressed log number S-001365-12

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Programs Manager, Food Services Manager, Registered Nursing Staff, Personal Support Workers, residents and family members.

During the course of the inspection, the inspector(s) conducted a walk through of resident home areas and various common areas, observed the provision of care and services to residents of the home, reviewed various procedures and protocols and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:
Personal Support Services

Recreation and Social Activities

Findings of Non-Compliance were found during this inspection.

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

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (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).

Findings/Faits saillants :

1. On March 14, 2013, resident #900 was observed seated in a wheelchair which was tilted backward at a 45 degree angle. The resident was slumped forward with their forehead nearly resting on both knees. Neither a seat belt nor chair alarm was applied to the resident. Resident #900's plan of care identifies a tilt wheelchair as the resident's primary mode of locomotion. The plan of care directs nursing staff to ensure the Posey alarm is in place and the two point front release seat belt is applied when resident #900 is seated in the wheelchair. Physiotherapy goals and interventions for resident #900 identify that the resident would benefit from repositioning to encourage extended positions and also recommend elevation of resident #900's head when the resident is in a seated position. The licensee failed to ensure the care set out in the plan of care was provided to the resident. [s. 6. (7)]

2. On March 14, 2013 resident #250 was observed seated in a tilt wheelchair, which was parked in the hallway directly outside of the 3rd floor TV lounge. A wheelchair alarm was not observed on the wheelchair. The plan of care identifies a tilt wheelchair as resident #250's primary mode of locomotion. The plan of care directs staff to ensure the Velcro seat belt alarm is applied when resident #250 is seated in the wheelchair. The plan of care also identifies that resident #250 "prefers to watch TV in the TV lounge". The TV screen was not visible from where resident #250 was positioned in the hallway. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

3. The plan of care for resident #350 contains goals focused on halting the resident's weight loss. Interventions contained in resident #350's dietary plan of care direct staff to encourage resident #350 to consume at least 75% of meals and document resident #350's food and fluid intake on the nutrition monitoring record. The Inspector reviewed the resident's nutrition monitoring record and noted that resident #350's food and fluid intake had not been recorded for the time period of March 1, 2013 to March 14, 2013.The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

4. Providing care as set out in the plan of care has been the subject of a previous Compliance Order (inspection 2012_053122_0014, CO #914, issued October 15, 2012 with a compliance date of March 9, 2013). [s. 6. (7)]

5. Resident #200's plan of care identifies a tilt wheelchair as the resident's primary mode of locomotion. The plan of care directs staff to apply the Posey alarm and the 4

point positioning seat belt with side release buckle when the resident is up in the wheelchair. On March 14, 2013, resident #200 was observed in the hallway seated in a wheelchair. A Posey alarm was not applied to the resident nor was one observed on the resident's wheelchair. The Inspector interviewed resident #200's family member in regards to resident's safety requirements when resident #200 is in the wheelchair. The family member reported that a Posey alarm had been applied on resident #200's previous wheelchair because the wheelchair was too large and caused resident #200 to slide out. The family member also reported that resident #200 has acquired a new wheelchair. Resident #200's new wheelchair is a better fit and as a result the Posey alarm is no longer required when the resident is seated in the wheelchair. The licensee failed to ensure that the resident's plan of care was reviewed and revised when the resident's care needs changed or when care set out in the plan of care was no longer necessary. [s. 6. (10) (b)]

6. Resident #600 was identified by staff as a cognitively impaired resident who receives 1:1 visitation due to their reluctance of participating in group activities. The plan of care identifies resident # 600 is at risk of social isolation and decreased cognitive stimulation and also identifies the resident's preference of talking and conversing 1:1. Resident #600's health care record was reviewed; however, the Inspector was unable to locate a recent recreation and social activity assessment. The Inspector interviewed staff #2000 who reported that assessments are completed upon admission only. Staff #2000 further reported that the recreation and social activity plans of care are updated through informal data gathering which utilize statistics or resident attendance rather than formal assessment tools or the resident's input. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan of care is no longer necessary. [s. 6. (10) (b)]

7. Resident #700 was identified by staff as a cognitively impaired resident who receives 1:1 visitation due to the resident's reluctance of participating in group activities. The plan of care identifies resident #700 is at risk of social isolation and decreased cognitive stimulation and also identifies resident #700's preference of talking and visiting in her room 1:1. Resident #700's health care record was reviewed; however, the Inspector was unable to locate a recent recreation and social activity assessment. The Inspector interviewed staff #2000 who reported that assessments are completed upon admission only. Staff #2000 further reported that the recreation and social activity plans of care are updated through informal data gathering which

utilize statistics or resident attendance rather than formal assessment tools or the resident's input. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan of care is no longer necessary. [s. 6. (10) (b)]

8. Resident #800 was identified by staff as a cognitively impaired resident who receives 1:1 visitation due to their reluctance of participating in group activities. The plan of care identifies resident #800 is at risk of social isolation and decreased cognitive stimulation and identifies the resident's preference of talking and conversing with others. Resident #800's health care record was reviewed; however, the Inspector was unable to locate a recent recreation and social activity assessment. The Inspector interviewed staff #2000 who reported that assessments are completed upon admission only. Staff #2000 further reported that the recreation and social activity plans of care are updated through informal data gathering which utilize statistics or resident attendance rather than formal assessment tools or the resident's input. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan of care is no longer necessary. [s. 6. (10) (b)]

9. Reassessment of the resident, review and revision of the plan of care at least every six months has been the subject of a previous Compliance Order (inspection 2012_053122_0014, CO #913 issued October 15, 2012 with a compliance date of March 9, 2013). [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 002 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. 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. On March 14, 2013 at 1350 hrs, the Inspector arrived on the 6th floor by way of the south end stairwell. Upon opening the stairwell door leading to the 6th floor hallway, the Inspector was able to see directly into room 602 and observe resident #500 lying on the bed facing the doorway. Resident #500 was naked from the waist down with genitals exposed while a staff member provided continence care to the resident. The licensee failed to ensure the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respect's the resident's dignity. [s. 3. (1) 1.]

2. The resident's right to be treated with courtesy and respect has been the subject of three previous written notifications and one voluntary plan of corrective action: inspection #2011_106_1159_04, issued at the January 5, 2011 inspection; inspection # 2011_054133_0006, issued at the July 5, 2011 inspection; inspection #2012_053122_0014, issued October 15, 2012 [s. 3. (1) 1.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 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. On March 14, 2013 resident #300 was observed in bed sleeping. The resident's call bell was wrapped around the side rail and hanging on the floor out of the resident's reach. The licensee failed to have a resident-staff communication response system that can be easily seen, accessed and used by residents, staff and visitors at all times. [s. 17. (1) (a)]

2. On March 14, 2013, resident #400 was observed seated in her tilt wheelchair, which was reclined. The resident was covered in a blanket, with the wheelchair placed directly beside and parallel to the bed. The resident's call bell was observed on the bed and out of the resident's reach. The resident's plan of care identifies that the resident suffers from impaired vision and is dependent on staff for all mobility and transfers. The licensee failed to have a resident-staff communication response system that can be easily seen, accessed and used by residents, staff and visitors at all times. [s. 17. (1) (a)]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #912	2012_053122_0014	122

Issued on this 6th day of June, 2013

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