Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 7, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, 27, 2012	2012_043157_0030	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF KAWARTHA LAKES
26 Francis Streeet, LINDSAY, ON, K9V-5R8

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

VICTORIA MANOR HOME FOR THE AGED
220 ANGELINE STREET SOUTH, LINDSAY, ON, K9V-4R2

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

PATRICIA POWERS (157), CAROLINE TOMPKINS (166), CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Director of Care(ADOC), Building Services Manager(BSM), Maintenance, Registered Dietitian(RD),Dietary Aide (DA), Assistant Manager of Dietary Services(AMDS), Manager of Resident and Family Services, Life Enrichment Aides, Office Manager, Senior Accounts Clerk, Infection Control Nurse, RAI Coordinator,Physio Therapist (PT), Physio Therapist Assistant(PTA), Resident Council President, Family Council President, Registered Nurses (RN), Registered Practical Nurses (RPN)Behavioural Support Team, Personal Support Workers (PSW), Residents and Family members.

During the course of the inspection, the inspector(s) Observed resident care and staff/resident interaction, food service, medication administration and storage areas, physical environment of the home, reviewed resident's clinical health records, policy, programs and procedures related to resident care and facility organization and resident business files.

During the course of this inspection the following Critical Incident was inspected;
Log# O-001185-12

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Skin and Wound Care

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.) 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 subsections:

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

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

Findings/Faits saillants :

1. Resident# 681 had surgery and was readmitted to the home with a daily dressing order. The written plan of care does not provide direction to staff and others who provide direct care to the resident, related to wound care.

The written plan of care for resident #681 does not provide clear direction to staff and others who provide direct care to the resident, related to interventions initiated in response to a previous fall.(194)

Log # O-001185-12
The plan of care for resident #01 identifies an incident of aggression. The written plan of care identifies the need for increased monitoring. There is no clear direction to the staff and others who provide direct care to the resident related to monitoring interventions.(166)

Plan of care for resident #833 identifies that the resident has been assessed as being at high risk for falls. There is no clear direction to the staff and others who provide direct care to the resident related to interventions for falls prevention. (157)

The clinical health record for resident #883 identifies that the resident has wounds. There is no clear direction to the staff and others who provide direct care to the resident in the written plan of care, related to the resident's wound care. (157)

The plan of care for resident #675 identifies that the resident is incontinent of bladder and continent of bowel. The staff have confirmed that the resident is incontinent of bowel and bladder. There is no clear direction to the staff and others who provide direct care to the resident in the written plan of care, related to the resident's continence.(194)

The plan of care for resident #769 directs a toileting routine for the resident. Staff have confirmed that this resident is no longer toileted due to the resident's current status. There is no clear direction to the staff and others who provide direct care to the resident in the written plan of care, related to the resident's toileting needs.[s.6.(1)(c)](166)(157)
2. The plan of care for resident #675 indicates that a wound treatment was started with no evidence of an assessment. [s.6.(2)]
3. Resident # 883 was receiving wound care treatments. Review of wound treatment records indicate:
- that a dressing to wound #1 be changed every 2-3 days, was not changed for an identified period of 9 days.
- that a dressing to wound #2 be changed every 2-3 days, was not changed for an identified period of 4 days.
The care for resident #883 was not provided as set out in the plan of care.(157)

The plan of care for resident #675 identifies a dressing to be changed every 5-7 days until healed. Documentation indicates that treatment was provided as ordered for an identified period of time. There is no evidence of the treatment being provided to the resident after this period. The care for resident #675 was not provided as set out in the plan of care (194)

The plan of care for resident #769 identifies specific programming that the resident participates in. Direct care and activity staff confirm that the resident is no longer capable of participating in these activities. The care for resident #769 was not provided as set out in the plan of care.(166)

The plan of care for resident #769 directs that the resident is to be toileted routinely. Interview with direct care staff indicate that the resident is not toileted due to a change in physical status. The care for resident #769 was not provided as set out in the plan of care.(166)

A physician order for a lab test was received for resident #675. Staff confirmed that this test was not completed. The care for resident #675 was not provided as set out in the plan of care.[s.6.(7)]
4. Staff confirm that the resident #769 does not actively participate in recreational and social activities. The plan of care for resident #769 directs that the resident actively participates in programs. The plan of care does not reflect a reassessment of the resident's ability to participate in recreational and social activities.(166)

The plan of care for resident #675 is not based on an assessment of the needs of the resident. The wound treatment provided was discontinued with no evidence of assessment.(194)

A Physio assessment on June 22, 2012 for resident #675 resulted in a therapeutic intervention. Staff and Physio have confirmed that this intervention is no longer in place. There is no evidence in the plan of care of reassessment for the discontinuation of the identified intervention.[s.6.(10)(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 plan of care;
- provides clear direction to staff and others who provide direct care to the resident
- is based on an assessment of the resident
- that care set out in the plan of care is provided as specified in the plan of care
- reflects a reassessment when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. There is no structured program in place to monitor, analyze, evaluate and improve the quality of accommodation, care services, program and goods provided to the residents.

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 shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents, to be implemented voluntarily.

WN #3: 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 subsections:

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

Findings/Faits saillants :

1. In accordance with the requirements of O.Reg. 79/10 s.49(1)the Falls Prevention Program must provide for strategies to reduce or mitigate falls, including the monitoring of residents and implementation of restorative care approaches.

The licensee's policy for "Falls Prevention and Management Program" (VM-NSG-069-January 28,2011) requires that a written care plan is based on needs, behaviours, medications, interventions and strategies to reduce risk.

Care plans for residents #681 and #683 identified as being at risk for falls do not provide written direction to staff in accordance with the policy requirements of the home, related to needs, behaviours, interventions and strategies to reduce risk.[s.8(1)(b)](194)

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 licensee's plans, policies, protocols, procedures, strategies or systems are complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following subsections:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. Log # O-001185-12
There is no evidence to indicate that the Substitute Decision Makers for residents #01 and #02 were notified of the results of an investigation of alleged abuse.[s.97.(2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident and resident's substitute decision maker are notified immediately of the results of an investigation of an alleged, suspected or witnessed incident of abuse or neglect of a resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

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

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

Findings/Faits saillants :

1. Actions taken with respect to residents under a program required under section 8-16 of the Act and section 48 of the Regulations are not consistently documented.

"Pressure Ulcer/Wound Assessment Record" and "Ulcer Tracking Record" for resident #883 were not completed. Information to be documented with every dressing change for resident #883 is not completed in accordance with program requirements.(157)

The "Pressure Ulcer Wound Assessment Record" was not completed weekly by a member of the registered nursing staff for treatments for resident #675 for two identified periods of time.(194)

The "Pressure Ulcer Wound Assessment Record" was not completed weekly by a member of the registered nursing staff for resident #883 for ongoing wound treatment.(157)

There is no evidence of Continence Assessments for resident #769, despite a significant change in the resident's status. [s.30(2)](166)
2. There is no written record relating to each evaluation of the programs required under section 8-16 of the Act and section 48 of the regulation.[s.30(1)4]
3. There is no evidence that the Programs required under sections 8 to 16 of the Act and section 48 of the Regulation are evaluated and updated at least annually.[s.30(1)3]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the programs required under section 8-16 of the Act and section 48 of the Regulations;
- are evaluated and updated annually
- written records relating to each evaluation is maintained
- actions taken with respect with a resident under the programs are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. Resident #883 was admitted with wound dressings, there is no evidence that an assessment of the areas dressed was completed by a member of the registered nursing staff, within 24 hours of admission.[s.50(2)(a)(i)]
2. Resident #883 was admitted to the home with pressure ulcers. There is no evidence of a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument designed for skin and wound assessment.

The licensee's policy for "Skin and Wound Program" (VM-NSG-071- August 25,2011) requires that "Pressure Ulcer/Wound Assessment Record" and "Pressure Ulcer Tracking Record" are to be completed by registered nursing staff for assessment and tracking of wound care. The policy further requires that "Wound Treatment" form is to be completed after a dressing changes related to the size of the wound, discharge from the wound, appearance, progression, pain, nutrition.

There is no evidence that the "Pressure Ulcer/Wound Assessment Record" and "Pressure Ulcer Tracking Record" are completed for resident #883. The "Wound Treatment" form for resident #883 was incomplete.[s.50(2)(b)(i)]

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 resident at risk for altered skin integrity receives a skin assessment within 24 hours of admission.
- a resident exhibiting altered skin integrity receives a skin assessment using a clinically appropriate assessment instrument and is reassessed weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information

Specifically failed to comply with the following subsections:

s. 225. (1) For the purposes of clause 79 (3) (q) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 79 of the Act includes the following:
1. The fundamental principle set out in section 1 of the Act.
2. The home's licence or approval, including any conditions or amendments, other than conditions that are imposed under the regulations or the conditions under subsection 101 (3) of the Act.
3. The most recent audited report provided for in clause 243 (1) (a).
4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service.
5. Together with the explanation required under clause 79 (3) (d) of the Act, the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act. O. Reg. 79/10, s. 225 (1).

Findings/Faits saillants :

1. The most recent audited report provided for in r. 243(1)(a) is not posted.[s.225.(1)3]

WN #8: 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 does not maintain a record setting out the improvements made to the quality of the accommodation, care, services, program and goods provided to the resident.[s.228.4.i,ii,iii]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the implementation of a quality improvement and utilization system providing a written description of its goals, objectives, policies, procedures and protocols. The licensee shall maintain records setting out the improvements, who participated in program evaluations and shall ensure communication with resident and family councils, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program
Specifically failed to comply with the following subsections:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1.Residents are not offered immunization against Tetanus and Diphtheria in accordance with the publicly funded immunization schedules.[s.229(10)3]

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

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The written plan of care for resident #769 directs staff related to toileting needs. Staff confirm that this resident is not toileted due to declining physical status.[s.51.(2)(b)]
2. There is no evidence that a Bladder and Bowel Continence Assessment form was completed for resident #675 and resident #769.

The licensee's policy for "Continence Care and Bowel Management Program" (VM-NSG-073-August 11,2008) requires that a Bladder and Bowel Continence Assessment be completed identifying causal factors, patterns, type of incontinence, potential to restore function. Assessments are to be completed quarterly and after any change in condition that may affect bowel or bladder continence.

Resident #769 was assessed on admission as being continent. There is no evidence of further assessments, despite a significant change in status resulting in total incontinence.[s.50.(2)(a)](166)

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee's policy "Minimizing of Restraining: Use of Restraints (VM-NSG-067-January 10,2011) requires that the resident's condition and need for ongoing restraint be reassessed at least every eight hours by registered nursing staff.

There is no evidence that residents #711, 681 and 870 were reassessed for the need of ongoing restraints use, every 8 hours by registered nursing staff as required.[s.110.(2)6]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The home is not completing a monthly analysis of restraining of residents.

Resident #711 uses 2 full bed rails when in bed. "Physical Restraint Monitoring Record" identified bed rails as a restraint. The monitoring of the restraint is completed by staff on an hourly basis. There is no evidence that this restraint has been analyzed monthly.[s.113.(a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. Accessibility to the store room for stock medication located in the basement of the home was not restricted to persons who may dispense, prescribe or Administer drugs and the administrator. A nursing clerk had a key and accessibility to the store room.[s.130.2]](166)(157)

This issue was corrected prior to the end of the inspection.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following subsections:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The registered dietitian did not complete a nutritional assessment of resident #111114 until 28 days after the resident was admitted to the home.[s.26(4)(a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

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).

Findings/Faits saillants :

1. The daily menus were not communicated to residents in Victoria and Elford house on September 10 & 11, 2012.[s.73 (1)1]

WN #16: 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 subsections:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. Log # O-001185-12
There is no evidence to indicate that the Director was advised of the results of the investigation of an alleged abuse.[s.23 (2)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following subsections:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) an explanation of the duty under section 24 to make mandatory reports;
(e) the long-term care home's procedure for initiating complaints to the licensee;
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints;
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained;
(h) the name and telephone number of the licensee;
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home;
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home;
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges;
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge;
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs;
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents;
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package;
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations;
(q) an explanation of the protections afforded by section 26; and
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. Information about whistle blowing protection is not provided in the admission package[s.78.(2)(q)]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following subsections:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) an explanation of the duty under section 24 to make mandatory reports;
(e) the long-term care home's procedure for initiating complaints to the licensee;
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints;
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained;
(h) the name and telephone number of the licensee;
(i) an explanation of the measures to be taken in case of fire;
(j) an explanation of evacuation procedures;
(k) copies of the inspection reports from the past two years for the long-term care home;
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years;
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years;
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council;
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council;
(p) an explanation of the protections afforded under section 26; and
(q) any other information provided for in the regulations. 2007, c. 8, ss. 79 (3)

Findings/Faits saillants :

1. The homes policy on "Minimizing Restraining of Residents" was not posted in a conspicuous and easily accessible location.[s.79.(3)(g)]
The "Minimizing Restraining of Residents" policy was posted prior to the completion of the inspection.

2. The homes policy on "Abuse of Residents" was not posted in a conspicuous and easily accessible location.[s.79.(3)(c)]
The "Abuse of Residents" policy was posted prior to the completion of the inspection.

3. The name and telephone number of the licensee was not posted in a conspicuous and easily accessible location. [s.79,(3)(h)]
The name and telephone number of the licensee was posted prior to the completion of the inspection.

4. The explanation of whistle blowing protections was not posted in a conspicuous and easily accessible location.[79.(3)(p)]
The explanation of whistle blowing protection was posted prior to the completion of the inspection.

5. The Long Term Care Homes procedures for making complaints to the licensee were not posted in a conspicuous and easily accessible location. [s.79.(3)(e)]
The Long Term Care Homes procedure for making complaints to the licensee were posted prior to the completion of the inspection.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Issued on this 27th day of September, 2012

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

Pat Thurs #157

Chantal Lafreniere (#194)

(#166).