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**

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, L1K-0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, L1K-0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670


## 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 |
|---|---|---|---|
| Oct 21, 2014 | 2014_362138_0014 | O-000921-14 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

BRUYERE CONTINUING CARE INC.
43 BRUYERE STREET, OTTAWA, ON, K1N-5C8

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

ÉLISABETH-BRUYÈRE RESIDENCE
75 BRUYERE STREET, OTTAWA, ON, K1N-5C8

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

PAULA MACDONALD (138), ANGELE ALBERT-RITCHIE (545), LINDA HARKINS (126), LISA KLUKE (547)

**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): September 29, 30, October 1, 2, 3 6, 7, 8, 9, and 10, 2014**

**The following Complaint Inspections were conducted as part of the RQI:**
**O-000394-14**
**O-001117-13**

**During the course of the inspection, the inspector(s) spoke with Residents, Family members, Private Care Sitters, Volunteers, Students, Elevator Guards, the President of the Residents' Council, the Director of Mission Ethics, Compliance, and Client Relations, a member of the Family Council, Registered Nurses (RN's), Registered Practical Nurses (RPN's), Personal Care Attendants (PCA's), a Ward Clerk, the Administrative Assistant, Housekeeping Attendants, Food Service Attendants (FSA's), a Diet Technician, the Registered Dietitian (RD), the Administrator, the Advanced Practice Nurse for LTC and Clinical Manager (Director of Care (DOC)), the Manager of Food Services, a Meal Helper, the Supervisor of Housekeeping and Environmental Services, the Facilities Manager, the Director of Emergency Preparedness and Environmental Services, the Recreation Technician, a Pharmacy Technician, a Physician, a Security Attendant, a Physiotherapy Assistant, and a Medical Records Technician.**

**During the course of the inspection, the inspector(s) toured residential and non residential areas, observed several meal and snack services, reviewed several of the home's policies and procedures, reviewed the home's Admission Package and Resident Contract Agreement, observed a medication pass including medication room, observed recreation activities, observed exercise therapy, reviewed minutes for Residents' Council and Family Council, reviewed the Quality Improvement Committee, reviewed Resident Health Care records, reviewed the Recreation Calendars, reviewed staffing schedules, reviewed food service documentation, reviewed cleaning schedules, and reviewed maintenance schedules.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**
**Accommodation Services - Laundry**
**Admission and Discharge**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Food Quality**
**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**
**Reporting and Complaints**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Snack Observation**
**Sufficient Staffing**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 76. Training**

**Specifically failed to comply with the following:**

**s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).**

**Findings/Faits saillants :**

1. According to the Act section 76 (1), every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section which includes subsection 76 (2) 1 Residents' Bill of Rights and subsection 76 (2) 3 the long term care home's policy to promote zero tolerance of abuse and neglect of residents. According to the Act subsection 76 (4) every licensee shall ensure that the

persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. In accordance with the regulation section 219 (1), the retraining intervals for the purposes of subsection 76 (4) of the Act are annual intervals.

During resident and family interviews conducted as part of Stage 1 of the Resident Quality Inspection (RQI), several residents and a family member indicated to Long Term Care Homes (LTCH) inspectors #545, #126, and #547 that they experienced incidents of not being treated with respect and dignity. As a result of these comments LTCH Inspector #545 interviewed staff about the training they received, specifically related to Residents Bill of Rights and the home's policy to promote zero tolerance of abuse and neglect of residents as well as reviewed the home's mandatory training program with respect to the Act.

LTCH Inspector #545 spoke with a PCA, Staff #128, who indicated that she was hired in the organization several years ago but that she had been working in the long-term care home for about a week. Staff #128 added that she had received her training on Residents' Bills of Rights and the prevention of abuse and neglect of residents however, upon review of the home's Employee Mandatory eLearning Report, it was documented that Staff #128 had not received training in these two areas or any other training in outlined per the Act subsection 76 (2).

LTCH Inspector #545 spoke with another PCA, Staff #134, on October 8, 2014 who indicated that she was a casual employee recently employed in the home, adding that she accepted a position at the home during the restructuring in March 2014. Staff #134 indicated she had not received the home's mandatory training program as of yet, including training on Residents' Bill of Rights and the home's abuse and neglect policy. The DOC arrived during the discussion and informed Staff #134 that arrangements would be made to allow for the mandatory training.

LTCH Inspector #545 reviewed the home's Passport to Learning for Long-Term Care Staff (October 2013—January 2014), comprised of seven Modules, including Residents' Bill of Rights and the home's policy to promote zero tolerance of abuse and neglect of residents as well as other mandatory training as per legislation. It is described as follows:

- Module 1: Home Mission Statement, Residents' Bill of Rights, Whistleblowing Protection
- Module 2: Pleasurable Dining

- Module 3: Abuse and Neglect
- Module 4: Least Restraint, Last Resort
- Module 5: Protect Residents, Prevent Falls
- Module 6: Continence Care and Bowel Management
- Module 7: Preventing Pressure Ulcers in Long-Term Care

Further, LTCH Inspector #545 reviewed the home's Employees Mandatory E-Learning Report (dated: March 2013 to September 30, 2014) provided by the Administrative Assistant, Staff #133. It was documented that 28 out of 82 staff (registered nursing staff, PCA's and Meal Helpers) or 34% had not received Residents' Bill of Rights training and 29 out of 82 (35%) had not received the training of the long-term care home's policy to promote zero tolerance of abuse and neglect of residents. The inspector held a discussion with the DOC on October 8, 2014 regarding the training of staff and the DOC indicated that she was aware that not all staff had received the home's mandatory training program, as per the Act, and had already made plans to follow-up with individual staff in one-on-one meetings.

Additionally, on October 6, 2014, LTCH Inspector #545 spoke with a contracted staff member, Staff #127, who indicated that employment at the home commenced three weeks ago and that Staff #127 had not received training on Resident's Bill of Rights, the home's abuse and neglect policy or any other mandatory training. A Meal Helper, Staff #131, indicated to the inspector that she was hired 18 months ago and was provided training on Residents' Bills of Rights and the home's abuse and neglect policy as part of her orientation but had not been requested to do any further retraining.

During a discussion with LTCH Inspector #138, a student, Staff #113, indicated to LTCH Inspector #138 that she was provided an orientation when she started at the home but that she had not received training on the Residents' Bill of Rights or the home's abuse and neglect policy. A teacher for a local college who supervises student placements at the home, Staff #115, stated to LTCH Inspector #138 that she had not received training on the home's abuse policy nor has she received retraining on Residents' Bill of Rights or the home's abuse and neglect policy in the two years she has been at the home.

LTCH Inspector #545 spoke with the DOC on October 8, 2014 regarding the training needs according to the Act for students in the home. The DOC stated that the home's mandatory training program is not offered to students as students work with staff from

the home who have already received the training. She also indicated that contract staff members such as the elevator guards who monitor the elevator on the dementia unit on the sixth floor had not been offered the home's mandatory training program before starting employment. The DOC added that the home expected the elevator guards to provide assistance to staff if required such as sitting between two residents to prevent conflict. She indicated as well that she would expect the elevator guards to report to the registered staff any observed suspicious activity.

During another interview with the DOC on October 9, 2014 she confirmed that PCA and RPN students participated in direct care to residents and worked in the home pursuant to a contract/agreement between the licensee and third party. The DOC explained that the colleges were responsible for providing mandatory training as set out in the Act to the students prior to their clinical practicum in the home. The home was unable to demonstrate through the contracts that all mandatory training was provided to the students. [s. 76. (1)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**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).**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**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. 2007, c. 8, s. 3 (1).**

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**Findings/Faits saillants :**

1. The Licensee failed to ensure that every resident was treated with courtesy and

respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

During resident and family interviews as part of Stage 1 of the RQI, several residents and a family member indicated to LTCH Inspectors #545, #126 and #547 that they had experienced incidents of not being treated with courtesy and respect by staff.

In response, LTCH Inspector #545 reviewed of the minutes of the Residents' Council meetings. The minutes dated June 16, 2014 showed that the residents at the Residents' Council meeting had expressed a concern related to respect and dignity. The residents stated that staff were speaking a language not understood by residents, neither french or english, while caring for residents. The minutes reflected that the DOC had spoken with staff and ask for the situation to be monitored.

In addition, during an interview with the DOC on October 6, 2014, she indicated that she was hired on March 3, 2014 and that on March 16, 2014, thirty seven new staff started employment in the home through a restructuring of the organization. She indicated that she was aware that residents had concerns, and that there were resident complaints of staff being rough and unfriendly. She indicated that these comments came up in the Satisfaction Survey in April 2014, adding that the home was working on Mutual Respect as part of their Quality Improvement initiative. The DOC further stated that she had conducted one-on-one meetings with each PCA in the home, and reviewed their role including the importance of greeting residents at the beginning of each shift and to speak directly with them during care. The DOC indicated that she had each PCA complete and sign the "PCA Meeting with the DOC" agreement. [s. 3. (1) 1.]

2. During meal observations, LTCH Inspector #138 observed the use of baby food for residents on texture modified diets. The baby food was sent to the resident on his or her meal tray in its original packaging labelled as baby food. The inspector observed that that each resident who received the baby food was significantly cognitively impaired and would not be able to state how he or she felt about receiving baby food. The inspector spoke with the Manager of Food Services on October 3, 2014 regarding several items including the use of baby food for residents of the home. The manager stated that baby food is used in the home only as a back up as the home is able to source more appropriate texture modified menu items. The manager stated that if baby food is required to be used by the home than it should be presented to the residents in a more dignified manner.

LTCH Inspector #138 also observed over the course of several meal and snack observations that the home frequently relied on styrofoam cups for hot and cold beverages and other disposable products rather than appropriate dishes, cups and mugs that support the home-like environment that is outlined in the preamble to the Act. For example, sandwiches were observed on several occasions to be delivered to residents during the mealtimes in a clear plastic take out container as opposed to being placed on a plate. The inspector spoke with the DOC and the Manager of Food Services on October 8, 2014 regarding the use of such disposable products and the Manager of Food Services stated that the home is supposed to use plates for sandwiches. The Manager of Food Services also stated that she could arrange to have an adequate supply of dishes, including mugs and glasses, in the home for residents' use. [s. 3. (1) 1.]

3. During Stage 1 of the RQI, LTCH Inspector #138 completed the mandatory task of a dining observation which was conducted at lunch on the sixth floor dining rooms on September 29, 2014. It was observed by the inspector during this meal observation that there were seven residents seated in wheelchairs and that all seven of the residents were sitting on a light blue transfer sling while in their wheelchairs. The inspector returned to the same dining rooms on October 6, 2014 and this time observed nine residents sitting in wheelchairs. All nine of these residents were sitting on a blue transfer sling while seated in their wheelchairs. The inspector identified the nine residents and reviewed the current plan of care (as identified by the home) for each of the nine residents. There was no direction in any of the nine plans of care reviewed by the inspector that directed staff to leave residents sitting on a transfer sling while in a wheelchair. The inspector spoke with the DOC on October 7, 2014 regarding the transfer slings left under residents while they were seated in a wheelchair. The DOC stated that she had noted this practice in the home when she started six months ago and further added that this practice was a routine identified as a concern but that she felt it was not an immediate priority to address because staff transfer and reposition these residents. [s. 3. (1) 1.]

4. During Stage 1 of the RQI, Resident #050 expressed a concern related to the lack of food choices at meal times. LTCH Inspector #138 followed up with Resident #050. The resident stated that s/he is not able to select items from the menu and further added that s/he is capable of making his/her own food choices and would like to make these choices.

LTCH Inspector #138 spoke with the Manager of Food Services on October 3, 2014. The Manager of Food Services stated that the home offers menu items through one of two methods at the choice of the resident or the resident's substitute's decision maker. The first method, know as selective menus, is to offer choice of food items by having the resident fill out menus in advance of the meals. The second method, known as non-selective menus, is a predetermined menu that is set up with the resident or the resident's substitute decision maker based on the resident's needs and preferences. The Manager of Food Services stated that residents can make changes to their menus at any time.

LTCH Inspector #138 spoke with the Diet Technician on October 9, 2014 regarding Resident #050. The Diet Technician stated that Resident #050 is on a non-selective menu, meaning that the resident does not select choice from the menus, and would have previously agreed to be placed on a non-selective menu. She further stated that she would be able to arrange to have Resident #050 switched to a selective menu so that the resident would be able to make food choices from the available menus. [s. 3. (1) 1.]

5. The Licensee failed to ensure that every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

On October 6, 2014, LTCH Inspector #547 conducted an interview with Resident #058 who indicated s/he was embarrassed about his/her finger nails, as they were long and dirty. The resident indicated that s/he no longer goes in the tub as it takes too much energy, so staff give him/her a bath in bed. The resident indicated the staff often do not have time to cut the resident's finger nails, and since s/he eats with his/her hands, often gets food stuck in the nails. LTCH Inspector #547 observed the resident's finger nails to have brown matter stuck behind the nails and that the nails were long and sharp. Upon record review, it was noted that on the resident's basic care flow sheets that there were no initials noted for nail care since the beginning of the month of October 2014.

On October 7, 2014 LTCH Inspector #547 spoke with the DOC who stated that this is not acceptable hygiene care for the resident as her expectation is that all residents receive hand hygiene and nail care as part of their daily grooming. [s. 3. (1) 4.]

6. LTCH Inspector #138 was observing the breakfast meal service on the fifth floor the

morning of October 2, 2014. The inspector toured the floor and observed Resident #058 in bed with his/her breakfast tray set up in front of him/her on an over bed table. The inspector asked the resident if it is usual for him/her to eat breakfast in bed and the resident responded that it was not, adding that s/he preferred to be in the dining where there are other people. The inspector asked the resident why s/he was in bed that morning and the resident further responded by stating that s/he had not made the decision to stay in bed. The inspector proceeded to the unit RPN, Staff # 102, and asked about Resident #058's morning routine. Staff #102 stated that the resident usually eats in the dining room but was left in bed that morning because of bowel issues. The inspector asked for further information from Staff #102 who stated that the resident was constipated and clarified, when prompted by the inspector, that s/he was not is pain or distress but that staff would be working with the resident later that morning related to bowel care. The inspector later spoke with DOC regarding Resident #058 and the DOC stated that the resident should have gone to the dining room for breakfast and then returned to bed later. [s. 3. (1) 4.]

7. LTCH Inspector #138 observed several meal services on both the fifth and sixth floors over the course of the RQI and noted that residents were not offered water to drink at meals. It was noted during the review of resident health care records that Resident #071 and Resident #013 had specific direction in the current plan of care (as was defined by the home) to provided water with meals. The inspector monitored both residents during the meal services and observed that no water was offered to either resident at meal times nor to any other resident. The inspector spoke with the Registered Dietitian on October 8, 2014. The Registered Dietitian stated to the inspector that it is the expectation and the responsibility of the nursing staff to offer water to all residents at meals. The inspector spoke with home's DOC later that same day regarding the lack of water offered to residents at mealtimes. [s. 3. (1) 4.]

***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 residents are treated with dignity and respect by staff of the home when care is provided to residents, to be implemented voluntarily.***

**WN #3: 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. (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).**

**Findings/Faits saillants :**

1. The Licensee failed to ensure that there is a written plan of care for each resident that sets out the planned care of the resident.

LTCH Inspector #138 followed up on a concern voiced by a resident relating to a lack of food choices. The inspector had spoken with the Manager of Food Services on October 3, 2014 who stated that the home offers menu items through one of two methods at the choice of the resident or the resident's substitute's decision maker. The first method, know as selective menus, is to offer choice of food items by having the resident fill out menus in advance of the meals. The second method, known as non-selective menus, is a predetermined menu that is set up with the resident or the resident's substitute decision maker based on the resident's needs and preferences. The Manager of Food Services stated that residents can make changes to their menus at anytime.

LTCH Inspector #138 spoke with the Diet Technician on October 9, 2014 regarding selective and non-selective menus. The Diet Technician ran a report for fifth floor that demonstrated twenty-two residents received a non-selective menu. The inspector reviewed the current plans of care (as defined by the home) on the fifth floor and observed that there was no information in the plans of care directing staff to provide a non-selective menu to residents. [s. 6. (1) (a)]

2. The Licensee 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 care to the resident.

Resident #058 has his/her own teeth however s/he multiple issues with these teeth as indicated in the resident's plan of care dated 2014/08/13.

On September 30, 2014, LTCH Inspector #547 interviewed Resident #058 who indicated s/he preferred to have his/her teeth brushed morning and night. The resident indicated that his/her teeth are in terrible condition, as many are broken and chipped and that staff assist him/her with his/her mouth care as s/he cannot do this task alone. The resident indicated that his/her mouth care is not consistently completed, as staff are so busy they can only do his/her mouth care when they have time.

On October 6, 2014 upon record review, it was noted in Resident #058's basic care flow sheets that the resident is to receive oral hygiene on day and evening shifts. The resident's kardex indicates however that one staff assist for daily cleaning of teeth, and to lubricate the client's mouth and lips. The plan of care dated 2014/08/13 indicated to maintain oral hygiene for the resident daily with one staff to assist with daily cleaning of teeth.

On October 6, 2014, LTCH Inspector #547 noted that Resident #058 was utilizing a toothette upon entering the resident's room. The resident indicated that it was new to use this today as it had antiseptic in it. The resident further stated that s/he prefers to use a tooth brush and paste to clean his/her teeth.

Staff #142 indicated to LTCH Inspector #547 during an interview that this resident should have specialized directions in his/her plan of care for his/her mouth care due to the condition of his/her teeth. The DOC also indicated that the resident's mouth care in the current plan of care was not documented to be specific enough for his/her oral care needs as s/he has significant tooth decay, and would require specialized staff direction at this time for mouth care. [s. 6. (1) (c)]

3. On October 9, Resident #072's plan of care was reviewed by LTCH Inspector #126 after the inspector determined that the resident was using a seatbelt as a PASD when on the commode. No documentation was found in the plan of care or the kardex related to the use of a seatbelt as a PASD.

On October 9, 2014, LTCH Inspector #126 interviewed RPN, Staff #102, regarding the use of a seatbelt as a PASD for Resident #072 when on the commode. Staff #102 indicated that the application of the seatbelt while on the commode as a PASD for Resident #072 was not documented on the resident's plan of care. Staff #102

updated the resident's plan of care at that time to provide clear direction to staff. [s. 6. (1) (c)]

4. 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.

On October 2, 2014, LTCH Inspector #138 observed during the breakfast meal service on fifth floor that Resident #075 was brought to the large dining room and set up with a breakfast tray by staff at 8:40 am. Staff did not stay to assist the resident to eat nor did the resident eat independently. The inspector monitored the resident and observed a student provided verbal encouragement but no physical assistance to eat to Resident #075 at approximately 9:00 am. The inspector continued to monitor the resident through out breakfast and noted that by 9:25 am the resident had not been assisted with breakfast by any staff. It was noted that the resident did not eat anything independently. The inspector reviewed the plan of care (as defined by the home) for Resident #075 and noted that the plan of care indicates that Resident #075 requires total physical assist for eating. [s. 6. (7)]

5. At 9:45 am on October 10, 2014, LTCH Inspector #138 observed Resident #058 in The Villa Bistro dining room on the fifth floor seated alone at a table with his/her breakfast tray in front of him/her. It was noted by the inspector that the resident had only eaten a small part of the breakfast and that the resident was not eating at the time of the observation by the inspector. The inspector closely monitored Resident #058 over the course of the next hour and observed that the resident did not eat any more from the breakfast tray and that no staff came to assist the resident with the breakfast tray. The inspector reviewed the health record for Resident #058 noting the resident had a low body weight with a slight weight loss over the past three months. The current plan of care dated August 13, 2014 for the resident (as defined by the home) stated that the resident needs to be fed by staff when not eating. [s. 6. (7)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents requiring assistance with feeding are provided assistance as specified in the plan of care, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

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

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**Findings/Faits saillants :**

1. The Licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

During Stage 1 of the RQI, a concern was identified through a resident interview that the home was unclean. All LTCH Inspectors noted in Stage 1 of the RQI that most resident rooms were reasonably clean and tidy however, LTCH Inspector #138 observed that the servery on fifth floor appeared unclean in that the exterior cupboards were heavily soiled with finger prints and splattered substances, the interior of the the cupboard drawers contained crumbs and spill marks of a sticky substance, the wall near the dirty dishes trolly was soiled, the edges of the floor in the the servery that meets the baseboards was soiled with a build up of dark brown grime that was particularly heavy at the entrance to the servery. It was also observed by the inspector during Stage 1 that the dining room floors on sixth floor were unclean. The inspector continued to monitored the servery and dining rooms during Stage 1 and noted that the dining room floors often appeared unclean with chucks of food debris, crumbs, and shreds of paper.

LTCH Inspector #138 spoke with the Supervisor of Housekeeping and Environmental Services and the Director of Emergency Preparedness and Environmental Services on October 6, 2014 in the dining room on the fifth floor. Both the Supervisor and the Director were shown the dining room floor that was observed to have crumbs and food debris under the dining room tables. One portion of the floor was noted to be heavily littered with food debris where a specific resident sits. The Supervisor of Housekeeping and Environmental Services observed this and stated that the dining rooms are cleaned once a day in the afternoon and then as requested by the nursing department. He further stated that, with respect to the serveries, the serveries are refreshed daily and a full clean completed once a week. According to the cleaning schedule reviewed, the full clean of the serveries would have occurred after the inspector's initial observations noted above. The inspector proceeded to the servery and pointed out the exterior cupboards, wall, and flooring that remained unclean since the inspector's initial observations.

Later that day on October 6, 2014, the inspector returned to the fifth floor dining room as residents were beginning lunch and noted that the dining room floor had not been cleaned and that crumbs and food debris remained under and around the dining room tables. The area on the floor that was heavily littered with food debris where a particular resident sat also remained.

LTCH Inspector #138 continued to monitor the dining rooms and proceeded to tour all dining rooms on October 7, 2014 at approximately 11:00 am. It was observed by the inspector that the large dining room floor on the fifth floor was noted to have a large amount of crumbs under all the dining room tables. It was also observed that there were crumbs and dried yellow splatter marks on the floor in The Villa Bistro dining room, as well as crumbs, gum, and paper debris on the floor in the The Seguin's Room. On sixth floor, the large dining room was observed to have crumbs and food debris under all the tables and a large dark brown dried clump on the floor at a resident's table. Also, the floor in Alice's Corner had approximately five large yellow and brown chunks of a soft substance on the floor at a resident's table. The inspector toured all dining rooms again later that same day at the start of the lunch meal service when residents were beginning to eat and noted that the floors appeared as before and had not been cleaned.

Again on October 8, 2014, LTCH Inspector #138 toured the dining rooms on the fifth and sixth floor prior to 10:00 am and noted that the floors had crumbs and chunks of

food debris where residents had eaten. The inspector toured the dining rooms again at the start of the lunch meal service and it was observed that the floors remained unchanged with crumbs and food debris. [s. 15. (2) (a)]

2. The Licensee has failed to ensure that resident ambulation equipment is kept clean and sanitary.

On September 29, 2014, LTCH Inspector #545 observed Resident #078's electric wheelchair to be soiled with dust, food debris, stains and odours. The resident indicated that no one cleans the resident's wheelchair in the home.

On October 2, 2014 LTCH Inspector #545 observed Resident #082's electric wheelchair including the seatbelt to be dusty and soiled with sticky debris. The resident reported that the wheelchair was probably cleaned approximately two months ago.

On October 7, 2014, LTCH Inspector #547 observed Resident #075 to have a soiled wheelchair with dust, debris and white dried matter stuck to the seat and metal rails of the chair.

LTCH Inspector #547 conducted interviews with Resident's #052, #055, #059, and #078 who all indicated that their wheelchairs have not been washed in several months.

LTCH Inspector #547 conducted an interview with the Supervisor for Environmental Services and Housekeeping who indicated that it was not the housekeeping duties in the home to clean resident ambulation equipment.

LTCH Inspector #547 then conducted an interview with the DOC who indicated that the home does not have a process for cleaning of resident ambulation equipment with any department. [s. 15. (2) (a)]

3. The Licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

LTCH Inspector #138 conducted a dining observation on the sixth floor during Stage 1 of the RQI. It was noted by the inspector that the walls, doors, door frames, and window casings were heavily scratched.

LTCH Inspector #138 returned to the dining rooms and serveries on October 3, 2014 and noted the following:

The Villa Bistro (fifth floor) - the wall adjacent to the door was marked and chipped to the drywall in a two foot section from waist level to the floor. The door frame by the door latch was heavily chipped to the metal from waist level to the floor. The blue window sill of the interior windows was heavily scarred to the metal along the edges at waist level and at the bottom.

The Seguin Room (fifth floor) - the pale pink interior window was scarred to the metal along the bottom with horizontal lines running 1-6 inches in length. The pink wall containing the clock and closet door had black marks running horizontally about 1 foot from the bottom of the wall for a 5 foot span.

The Trillium Room (large dining room on the fifth floor) - the peach window sill (the interior window) is heavily scarred to the metal at waist level height and 6 inches from floor along the entire window which consists of four large window panes. The scarring has caused surfaces that are rough with sharp edges in areas accessible to residents. It was also noted that the wall next to the interior window was chipped and scarred. It was observed that the back door to the dining room was chipped down to the metal along the edges at the handles from waist level to the bottom of the door. The green harvest table was heavily scratched with multiple horizontal scratches on the legs showing the bare wood. The peach door jam into the severy from the dining room was heavily scarred to the metal from chest level to the floor on the right side. The peach door into the servery was also chipped to the metal along the edge with hinges and there were three horizontal scratches at the bottom of the door. The brown door to the servery from the hallway was chipped to the metal from waist height to the floor.

LTCH Inspector #138 spoke with Facilities Manager on October 9, 2014 regarding the maintenance of the dining rooms and the serveries and he was able to demonstrate the home's preventative maintenance program indicating that the dining rooms were painted approximately two years ago. The Facilities Manager stated that he agreed with the inspector that the dining rooms were in need of further repair. [s. 15. (2) (c)]

***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 resident ambulation equipment is kept clean and sanitary, to be implemented voluntarily.***

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**WN #5: 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).**

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**Findings/Faits saillants :**

1. The Licensee failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by resident, staff and visitors at all times.

On October 8, 2014 at 9:45 am, Staff #103 entered bedroom #550-Y to test the resident-staff communication and response system (also known as the call bell system or simply the call bell). Staff #103 and LTCH Inspector #545 were unable to see or access the call bell in the room. The inspector observed the staff member raise the resident's electric bed and then raise the head of bed to locate the call bell. The cord was wrapped around the metal frame of the bed, and tucked solidly under the

mattress.

Resident #090, who resides in room 550-Y, indicated to the inspector that s/he could not see or access the call bell. [s. 17. (1) (a)]

2. LTCH Inspector #138 toured the fifth floor of the home on October 2, 2014 during the breakfast meal service. The inspector observed that Resident #076 was seated in a wheelchair with his/her back to the door. The resident was observed to be eating breakfast from a tray placed on an over bed table. The inspector proceed to enter the room and noted that the resident's call bell was on the opposite side of the bed to where the resident was sitting and the resident indicated that she was not able to reach the call bell.

LTCH Inspector #138 further observed during the breakfast meal round on fifth floor that Resident #053 was observed in the resident's room, seated in a wheelchair in front of an over bed table containing a breakfast tray. The resident was observed to be eating breakfast. The inspector entered the room and observed that the call bell was attached to the bed rail on the opposite side of the bed to the resident and that the resident would not be able to easily manipulate himself/herself to the other side of the bed to access the call bell. Resident #053 requested the inspector pass the resident the call bell stating that s/he likes to have the call bell near in the event that s/he requires assistance. The inspector ensured that the resident had access to the call bell before leaving. On October 6, 2014, the inspector had a follow up discussion with Resident #053 and the resident stated that staff often forget to ensure that the call is accessible when s/he is eating breakfast in his/her room.

LTCH Inspector #138 again toured the home during breakfast on October 6, 2014. On the fifth floor the inspector observed that Resident #011's room door was closed. The inspector opened the resident's door and peered inside to see the resident seated in a wheelchair next to the bed with an over bed table containing a breakfast tray. The resident was observed by the inspector to be eating breakfast. The inspector went into the resident's room and observed that the resident's call bell was on the floor on the opposite side of the resident's bed and not within reach of the resident. The inspector spoke with a RPN, Staff #114, regarding the call bell belonging to Resident #011. Staff #114 went into the resident's room and stated that the resident should have the call bell near and proceeded to make the resident's call bell accessible to the resident. [s. 17. (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 the resident-staff communication system is accessible to residents eating meals in their rooms, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

**Specifically failed to comply with the following:**

**s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,**
**(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks; O. Reg. 79/10, s. 71 (1).**

**s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,**
**(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).**

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

**s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,**
**(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).**

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**Findings/Faits saillants :**

1. The Licensee failed to ensure that the home's menu cycle includes menus for regular, therapeutic and texture modified diets for both meals and snacks.

LTCH Inspectors spoke with several residents during Stage 1 of the RQI pertaining to care and services in the home. Concerns were identified related to the provision of beverages mid-morning, mid-afternoon and after supper and the provision of snacks mid-afternoon and after supper. It was observed by LTCH Inspector #138 during

Stage 1 of the RQI that the beverages provided to residents mid-morning and the snacks provided mid-afternoon were limited and repetitive. LTCH Inspector #138 spoke with the Manager of Food Services on October 3, 2014 and discussed many components of the food service system in the home including the menus for snacks. When asked about the snack menu, the Manager of Food Services stated that the home will provide individualized snacks to many residents but stated that the home does not have a snack menu. The manager further stated that a snack menu is a goal for the home to ensure that residents not on an individualized snack program are offered a variety of food items.

LTCH Inspector #138 continued to monitor the distribution of beverages and snacks mid-afternoon on October 8 and 9, 2014 and observed that those residents not on an individualized snack program were offered the same food items. A PCA, Staff #148, told the inspector that the mid afternoon snack and beverage pass was always the same food items.

On October 8, 2014, LTCH Inspector #138 spoke with the home's Registered Dietitian who also stated that the home did not have a snack menu in place and further stated that a snack menu should be implemented as there is not a lot of variety in the choices of food items offered to residents at snacks. [s. 71. (1) (b)]

2. The Licensee failed to ensure that the home's menu cycle is reviewed by the Residents' Council for the home.

LTCH Inspector #547 spoke with the President of the Residents' Council regarding activities of the Residents' Council, as this is a mandatory task of the RQI. During this discussion, the President of the Residents' Council stated to the inspector that s/he could not recall reviewing the home's menu at the Resident Council.

LTCH Inspector #138 spoke with the Manager of Food Services on October 3, 2014 regarding the menu review process for the home. The Manager of Food Service stated that there is a committee to approve the menu and that the home's Registered Dietitian sits on the committee. The Manager of Food Services confirmed, when asked by the inspector, that no resident of the home sits on this committee to review the menu. The Manager of Food Services further stated that new menu items are sometimes introduced to residents though tasting panels although she could not recall the last time a taste panel was conducted with the residents in the home.

LTCH Inspector #138 followed up with the President of the Residents' Council on October 6, 2014 regarding the home's menus. The President of The Residents' Council stated that s/he had been active with the Council for approximately three years and, again, stated that s/he could not recall having the opportunity to review the home's menus.

LTCH Inspector #138 spoke with the Diet Technician and the Registered Dietitian On October 8, 2014 regarding the home's menu. The Registered Dietitian did state that she sits on a committee to review the home's menus but stated that the home has not taken the menu to the Residents' Council for review.

LTCH Inspector #138 reviewed the minutes from the Residents' Council meetings for 2014 and 2013 as provided by the assistant to the Residents' Council, Staff #129. The inspector noted that there was no documentation in the minutes regarding any taste panels, menu review or approval, or menu feedback that was conducted by the home with the Residents' Council. [s. 71. (1) (f)]

3. The Licensee failed to ensure that each resident is offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

During stage 1 of the RQI, enough residents expressed not being offered a beverage in-between meals that the concern was triggered for follow up by an inspector during Stage 2 of the RQI.

LTCH Inspector #138 followed up on the expressed comments that residents were not being offered a beverage between meals. On October 6, 2014, the inspector spoke with Resident #078 and #088 who both reported to the inspector that they are not offered beverages after breakfast. Resident #078 stated that s/he is required to get his/her own beverage if s/he wants something. Resident #088 further stated that in addition to not being offered a beverage after breakfast s/he is not consistently offered a beverage in the afternoon.

LTCH Inspector #138 monitored the fifth floor the morning of October 6, 2014 to observe the home's practice of offering beverages to the residents after breakfast. The inspector spoke with the RPN, Staff #114, regarding the home's practice to offer beverages to residents after breakfast. Staff #114 stated that staff do not provide beverages to residents in the morning. Later that morning, at approximately 11:15

am, the inspector observed an individual who identified herself as a volunteer to offer some residents water or apple juice. The volunteer stated to the inspector that she is usually on the unit on Mondays to offer beverages to residents, that she starts out on the sixth floor then proceeds to the fifth floor. The inspector observed the volunteer's process for offering beverages to residents on the fifth floor and observed that not all residents were offered a beverage including Resident #056, #075, #078, #079, #081, #082 #087, and #088 who were all on the unit, awake and alert.

On October 7, 2014, LTCH Inspector #138 monitored both fifth and sixth floors for the offering of beverages to residents after breakfast. The inspector spoke with a PCA, Staff #122, regarding beverages being offered to residents after breakfast and Staff #122 stated that volunteers offer beverages to residents mid morning. She further stated that if a volunteer is not present than it is the RPN's responsibility to offer beverages with the medication pass. The inspector followed up with a RPN on the sixth floor, Staff #112, regarding the medication pass and Staff #112 stated the medication pass was conducted to coincide with the resident meal times, not between meals. The inspector continued to monitor both fifth and sixth floors all morning on October 7, 2014 and noted that there was not a volunteer that morning to offer residents beverages and, further, the inspector did not observe that any residents were offered a beverage.

On October 8, 2014, LTCH Inspector #138 observed two PCA's Staff #148 and #134, offer snacks and beverages to residents on the fifth floor in the afternoon. It was observed by the inspector that several residents were not offered a beverage including Resident #015, #016, #017, #018, #060, #075, #078, #087, #088. It should be noted that these residents were observed to be awake. The inspector returned to Resident #075 and spoke with the resident who was awake and alert, sitting in a wheelchair in his/her room. The inspector asked the resident if s/he wanted a beverage or a snack and the resident requested a specific beverage but declined a snack. The inspector communicated this request to the RN.

LTCH Inspector #138 spoke with the DOC regarding the offering of beverages and the DOC stated that she was surprised that residents were not being offered beverages. [s. 71. (3) (b)]

4. The Licensee failed to ensure that each resident is offered a minimum of a snack in the afternoon and evenings.

During stage 1 of the RQI, several residents expressed not consistently being offered a snack in the afternoon or evening. LTCH Inspector #138 spoke with the Manager of Food Services on October 3, 2014 who explained that residents are offered snacks in the afternoon from a snack cart. The snack cart will have either predetermined snacks which are labelled for specific residents or, for residents without a predetermined snack, a choice can be made from the available items on the snack cart.

LTCH Inspector #138 spoke with Resident #082 who stated that some people are offered a snack in the afternoon but that s/he is not. Resident #082 stated that s/he would like to be offered a snack in the afternoon.

LTCH Inspector #138 observed the fifth floor afternoon snack cart on October 8, 2014 that was distributed by two PCA's, Staff #148 and #134. It was observed by the inspector that not all residents were offered a snack including Resident #018, #060, #075, #087, and #088. The care plans were reviewed for these residents and there was no instructions that indicated that the resident were not to be offered snacks. [s. 71. (3) (c)]

***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 all residents are offered a beverage in the morning and afternoon, to be implemented voluntarily.***

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**WN #7: 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).**

**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:**
**8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).**

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**Findings/Faits saillants :**

1. The Licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, a review, subject to compliance with subsection 71(6), of meal and snack times by the Residents' Council.

LTCH Inspector #547 spoke with the President of the Residents' Council regarding activities of the Residents' Council, as this is a mandatory task of the RQI. During this discussion, the President of the Residents' Council stated to the inspector that s/he could not recall the Resident Council reviewing the home's meal and snack times.

LTCH Inspector #138 spoke with a RPN, Staff # 112, on the sixth floor regarding the times of the mid-morning beverage pass and the afternoon snack/beverage pass. Staff #112 stated that the mid-morning beverages offered to residents often conflicts with activities and she was not able to give the inspector a time as to when the mid-morning beverages were offered to residents.

LTCH Inspector #138 followed up with the President of the Residents' Council on

October 6, 2014 regarding the home's meal and snack times. The President of The Residents' Council stated that s/he had been active with the Council for approximately three years and stated that s/he could not recall the Residents' Council reviewing the meal and snack times in the home.

LTCH Inspector #138 spoke with the Registered Dietitian and the Diet Technician on October 8, 2014 regarding several items including the review of the meal and snack times by the Residents' Council. The Registered Dietitian stated that the Residents' Council has not reviewed the meal and snack times and further stated that the meal and snack times have always been set.

Later that same day, on October 8, 2014, LTCH Inspector #138 spoke with the DOC and the Manager of Food Services regarding several items including the review of the meal and snack times by the Residents' Council. Both managers could not say if the home's meal and snack times were reviewed by the Residents' Council.

LTCH Inspector #138 reviewed the minutes from the Residents' Council meetings for 2014 and 2013 as provided by the assistant to the Residents' Council, Staff #129. The inspector noted that there was no documentation in the minutes regarding any review of the meal and snack times with the Residents' Council. [s. 73. (1) 2.]

2. The Licensee failed to ensure that the home has a snack and dining service that includes, at a minimum, a process to ensure that food service workers and other staff assisting residents are made aware of the residents' diets, special needs, and preferences.

LTCH Inspector #138 observed several meal and snack services throughout the course of the RQI and noted that information related to resident diets, special needs, and preferences was not always available.

It was noted during the meal services observed that the resident tray tickets outlining the residents' diets were available to staff serving residents but that any information regarding special needs and preferences was not included on the tickets. It was noted that there were several students in the home assisting residents with meals during the course of the inspection. The inspector spoke with Staff #115, a teacher for the students, who stated that the resident dietary information could be found on the plan of care. The inspector also spoke with the home's RN, Staff #101, who also stated that the residents' dietary information could be found on the plan of care. The

inspector reviewed several residents' plan of care and noted that the plan of care (previously defined by the home) did not always outline dietary preferences or special instructions.

LTCH Inspector #138 observed several snacks passes in the afternoon and observed that there was not a process to ensure that staff delivering the snacks were aware a resident diets, special needs and preferences. For example, on October 2014, LTCH Inspector #138 spoke with Staff #134 who was preparing to distribute the afternoon snack pass. She stated that she was new to the home and was having difficulty with the snack pass as she was not familiar with the residents or their needs.

The inspector spoke with the Registered Dietitian on October 8, 2014 who stated that the dietary information on the plan of care was minimal. The Registered Dietitian stated that she does have documents that outlines the resident dietary preferences and special needs that could be reworked to provide point of service information for those serving and assisting residents with meals and snacks. [s. 73. (1) 5.]

3. The Licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident’s assessed needs.

LTCH Inspector #138 observed the sixth floor lunch meal service upon entry to the home on September 29, 2014. It was noted by the inspector that a resident's meal arrived to the dining room servery pre-assembled on individual resident trays. Each resident tray was observed to contain all courses of the meal including soup, entrée, dessert, cold beverage and a hot beverage. The trays also included special items such as nutritional supplements for specific residents. It was observed that the trays were delivered to the residents and that all courses along with special items were provided at once for all residents on the sixth floor.

A breakfast meal service was observed on the fifth floor on October 2, 2014 and another lunch meal service on the fifth floor was observed October 6, 2014. It was observed at these two additional meal services that residents continued to receive all courses of their meal at once via a tray. It was also observed by the inspector that as each meal proceeded, meal courses were not removed from the resident tables as residents were finished and, instead, items from each individual tray were placed in the centre of the dining table resulting in a collective pile of garbage, food lids, and dishes from all the residents sitting at each of the tables. Some tables seated up to

six residents and this resulted in a fairly substantial pile in the centre of these tables.

LTCH Inspector #138 spoke with the DOC and the Manager of Food Services on October 8, 2014 to discuss many items including the lack of course by course meal service offered to residents in the home. The DOC stated that it is not the expectation of the home to pile all the lids, garbage, and dishes in the middle of the resident table while the Manager of Food Service stated that staff should be clearing these items away from the tables and placing them in appropriate bins. [s. 73. (1) 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 home has a dining service that includes course by course service for each resident, to be implemented voluntarily.***

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

**Specifically failed to comply with the following:**

**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).**

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**Findings/Faits saillants :**

1. The Licensee has failed to ensure that drugs are secure and locked.

During stage 1 of the RQI, LTCH Inspectors #126, #547 and #138 observed medicated creams, nasal spray and medicated mouth rinse at the resident besides or on the sink/shelf in the resident bathrooms.

The following medications were observed:

-On September 30, 2014, it was observed in Resident #063's bathroom counter: 3 small jars, hydrocortisone cream 1% dated December 23, 2013, February 13, 2013 and September 23, 2013 and two tubes of barrier cream.

-On September 30, 2014 , it was observed in Resident #069's bathroom shelf: one small jar of betamethasone 0.1% cream dated July 9, 2014 and one bottle of solarcaine lotion.

-On September 30, 2014, it was observed in Resident #071's bathroom counter: one bottle of Chlorexidine Gluconate 12% oral rinse.

The above residents live on the dementia secure unit. [s. 129. (1) (a)]

2. On October 8, 2014, at 10:45 am, while completing an observation of Resident #059's shared bathroom, LTCH Inspector #547 observed a small plastic cup with yellow liquid fluid on the bedside table while Resident #059 was sleeping.

Discussion was held with an RPN, Staff #102, who indicated that she does not usually leave medication at the bedside, except for this morning with the morning medication pass, she left Resident #059's, yellow liquid (lactulose) in a small plastic cup at the bed side. [s. 129. (1) (a)]

3. 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.

On October 1, 2014, LTCH Inspector #126 reviewed the nursing storage room on the sixth floor. It was observed in an unlocked fridge located in the medication room that there were 9 vials of injectable Lorazepam. Lorazepam is in the family of benzodiazepine and is considered a controlled substance.

On October 1, 2014, LTCH Inspector #126 interviewed two evening nursing staff, Staff

#105 and Staff #106, who both indicated that benzodiazepine is not stored in a separate locked area within the locked medication cart.

On October 2, 2014, LTCH Inspector #126 interviewed nursing staff, Staff #101 and Staff #102 who both indicated that benzodiazepine is not stored in a separate locked area within the locked medication cart. The covering DOC, Staff #100, indicated that she was not aware that benzodiazepine was not double locked in this home.

On October 2, 2014, LTCH Inspector #126 interviewed a pharmacy technician, Staff #104, who indicated that she was not aware that benzodiazepine was required to be double locked. Staff #104 indicated that a system would be put in place to ensure that all controlled substances, such as benzodiazepine, are kept double locked. [s. 129. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are secure and locked on the secure unit, to be implemented voluntarily.***

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information**

**Specifically failed to comply with the following:**

**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. O. Reg. 79/10, s. 225 (1).**
**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. O. Reg. 79/10, s. 225 (1).**
**3. The most recent audited report provided for in clause 243 (1) (a). O. Reg. 79/10, s. 225 (1).**
**4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service. O. Reg. 79/10, s. 225 (1).**
**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).**

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**Findings/Faits saillants :**

1. The License failed to ensure that the information required is to be posted in the home and communicated to residents.

On September 29, 2014, LTCH Inspectors #545 and #126 conducted a tour of the home as this is a mandatory task of Stage 1 of the RQI. It was observed by both inspectors that multiple items that are required to be posted in the home were not posted at the time of the tour.

LTCH Inspector #138 conducted another tour of the home on October 3, 2014 and again on October 8, 2014 and observed that the following was not posted:

-the home's license or approval,
-the most recent audited report,
-the Ministry's toll-free telephone number for making complaints about homes and its hours of service,
-the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act.

LTCH Inspector #138 spoke with the DOC on October 7, 2014, as directed by the home's Administrator, regarding the lack of posting of the above items and she stated she would obtain copies of the above for posting. [s. 225. (1) 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 Ministry's toll-free number for making complaints about homes and it hours of service are posted, to be implemented voluntarily.***

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**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.**

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**Findings/Faits saillants :**

1. The Licensee failed to ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

LTCH Inspectors were required to observe forty resident room/beds during Stage 1 of the RQI from September 29 to October 2, 2014. Nineteen of these forty room/beds were noted to be in rooms shared with at least one other resident (this did not include semi private rooms). Of the nineteen room/beds observed, nine room/beds were observed to have privacy curtains that did not ensure sufficient privacy.

On October 3, 2014, LTCH Inspector #138 toured the home to further observe room/beds identified during Stage 1 of the RQI. The following observations were made:

Room 506-2 - the track for the ceiling lift runs over the track for the privacy curtain preventing the privacy curtain from being fully closed and leaving a twelve inch opening.

Room 510-1 - the track for the ceiling lift runs over the track for the privacy curtain preventing the privacy curtain from being fully closed and leaving a twenty-three inch opening at the entrance to the resident's room.

Room 604-1 – This bed has two tracks for privacy curtains. One privacy curtain is missing resulting in an opening of four feet at the entrance to the room. The second privacy curtain runs between the two beds facing each other is not long enough to extend over the entire length of the track resulting in an opening of thirty one inches.

Room 604-2 – This bed has two privacy curtains. The first privacy curtain that runs between the two beds facing each other is not long enough to extend over the entire length of the track resulting in an opening of thirty one inches. The second privacy curtain was also not long enough to extend fully in the track resulting in another opening that is approximately four inches at the entrance of the room.

Room 614-1 – the track for the ceiling lift runs over the track for the privacy curtain preventing the privacy curtain from being fully closed and leaving a four foot opening.

Room 614-2 - the track for the ceiling lift runs over the track for the privacy curtain preventing the privacy curtain from being fully closed and leaving a four foot opening.

Room 619-1 – the track for the ceiling lift runs over the track for the privacy curtain preventing the ceiling curtain from being fully closed. The second privacy curtain is not long enough to cover the distance of the track leaving a twenty inch opening at the entrance to the resident room.

Room-634-1 - the track for the ceiling lift runs over the track for the privacy curtain preventing the privacy curtain from being fully closed and leaving a four foot opening at the entrance of the room.

Room 634-2 - the track for the ceiling lift runs over the track for the privacy curtain preventing the privacy curtain from being fully closed and leaving a twenty seven inch opening at the entrance to the resident's room.

Additionally, LTCH Inspector #138 noted in room/bed 619-1 the track for the ceiling lift runs over the track for the privacy curtain preventing the privacy curtain from being fully closed and leaving a ten inch opening at the entrance of the room.

LTCH Inspector #138 spoke with the Facilities Manager on October 7, 2014 regarding the above privacy curtains. The Facilities Manager stated that the home would be able to rectify the concerns identified above by installing additional tracks for the privacy curtains and/or installing additional privacy curtains. [s. 13.]

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**WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement**

**Specifically failed to comply with the following:**

**s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:**
**1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).**
**2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).**
**3. The use of the PASD has been approved by,**
**i. a physician,**
**ii. a registered nurse,**
**iii. a registered practical nurse,**
**iv. a member of the College of Occupational Therapists of Ontario,**
**v. a member of the College of Physiotherapists of Ontario, or**
**vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).**
**4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).**
**5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).**

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**Findings/Faits saillants :**

1. The Licensee has failed to comply with the Act section 33(4) 3. in that the Licensee did not ensure that the use of a Personal Assistance Service Device (PASD) is included in the plan of care and is only used if approved by a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario and or any other person provided for in the regulations.

On October 1, 2014, LTCH Inspector #545 conducted a resident room observation in room 519 and observed a commode chair with a buckle type seatbelt hanging on both sides, attached to metal tubular frame.

On October 2, 2014, LTCH Inspector #126 interviewed Resident #072 who indicated that s/he was the one using the seat belt in bathroom 519. Resident #072 indicated that the seatbelt is only used when s/he goes to the bathroom to ensure that s/he sits properly and doesn't slip and further stated that s/he is capable of undoing the seatbelt. At the time of the interview, Resident #072 was alert and oriented.

On October 8, 2014, LTCH Inspector #126 interviewed PCA, Staff #145, who indicated that when Resident #072 is toileted that the seatbelt is used on the commode to ensure proper seating and to prevent the resident from sliding off the commode. Staff #145, also indicated that she does not stay in the bathroom but stays in the room or very close as the resident is capable of ringing the call bell when s/he is done.

On October 9, 2014, LTCH Inspector #126 interviewed Physiotherapist Assistant, Staff #144, who indicated that she was not aware that Resident #072 has a seatbelt on the commode chair. Staff #144 reviewed Resident #072's health care record with LTCH Inspector #126 and did not find any note from the physiotherapist approving the utilisation of the PASD.

On October 9, 2014, LTCH Inspector #126 interviewed RPN, Staff #102, who indicated that she was not aware of anyone specifically approving the seatbelt as a PASD for Resident #072. [s. 33. (4) 3.]

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**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids**

**Specifically failed to comply with the following:**

**s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,**
**(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).**
**(b) cleaned as required. O. Reg. 79/10, s. 37 (1).**

**Findings/Faits saillants :**

1. The Licensee has failed to ensure that residents have their personal items labelled within 48 hours of admission and in case of new items, of acquiring in resident bathrooms for shared bedrooms.

On October 6, 2014, LTCH Inspector #547 observed in 24 out of 28 shared bathrooms on the fifth and sixth floors had residents personal items such as tooth brushes, toothpaste, hair brushes, deodorants sticks, razors, and kidney and wash basins situated on the counters of these bathrooms and did not have any resident names to identify these items.

On October 9, 2014, LTCH Inspector #547 observed a plastic bin in each of the fifth floor tub rooms containing items such as: combs with white flakes inside the bristles, four used disposable razors with hair and white matter lodged inside the blade, deodorant sticks with sticky clear matter on the outside of the container, specimen container with orange cap with vaseline/zinc cream written in pen on the outside, all of which did not have any resident name to identify these products.

On October 6, 2014, LTCH Inspector #547 interviewed the DOC who indicated that the home did not have a process in place at this time for labelling of residents' personal items upon admission or upon acquiring new items in the home. [s. 37. (1) (a)]

**WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council**

**Specifically failed to comply with the following:**

**s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).**

**Findings/Faits saillants :**

1. The Licensee has failed to ensure that it shall, within 10 days of receiving advice, respond to the Residents' Council in writing.

The President of Residents' Council indicated during an interview with LTCH Inspector #547 that the Residents' Council does not receive any written response from advice or concerns made to the Licensee by the Residents' Council. The President of the Residents' Council further specifically indicated that s/he brought forward a concern regarding menus to the Director of Care in August 2014 and, although the concerns were addressed and verbal communication was provided, no written response was provided to the Residents' Council.

LTCH Inspector #547 interviewed the DOC and the Administrator who both indicated that they verbally review any issues with families or residents as soon as they are received. The DOC indicated that some responses are captured in the Residents' Council minutes however the inspector noted that the Residents' Council minutes are not posted with 10 days of the meeting. The last Residents' Council meeting occurred in June 2014 and the minutes for this meeting were not yet ready for posting in the home at the time of the inspection. [s. 57. (2)]

**WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council**

**Specifically failed to comply with the following:**

**s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).**

**Findings/Faits saillants :**

1. The Licensee has failed to ensure that it shall, within 10 days of receiving advice, respond to the Family Council in writing.

On October 6, 2014, LTCH Inspector #547 interviewed the assistant to the Family Council who indicated that he was not aware of any written response provided for advice, concerns, or recommendations made to the Licensee by the Family Council.

On October 8, 2014, LTCH Inspector #547 interviewed a member of the Family Council who indicated that s/he provided advice to the DOC regarding a concern about the lack of supervision of the sixth floor lounge when residents are seated alone in this area. This Family Council member stated that s/he has not received any communication from anyone in the home about this issue.

LTCH Inspector #547 interviewed the DOC and the Administrator who both indicated that they verbally review any issues with families or residents as soon as they are received. [s. 60. (2)]

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**WN #15: 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:**

**s. 78. (2) The package of information shall include, at a minimum,**
**(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)**
**(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)**
**(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)**
**(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)**
**(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)**
**(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; 2007, c. 8, s. 78 (2)**
**(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; 2007, c. 8, s. 78 (2)**
**(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)**

**(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; 2007, c. 8, s. 78 (2)**
**(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; 2007, c. 8, s. 78 (2)**
**(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; 2007, c. 8, s. 78 (2)**
**(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)**
**(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; 2007, c. 8, s. 78 (2)**
**(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; 2007, c. 8, s. 78 (2)**
**(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)**
**(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; 2007, c. 8, s. 78 (2)**
**(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)**
**(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)**

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**Findings/Faits saillants :**

1. During the RQI, the home is required to self report on its package of information, otherwise known as the admission package. LTCH Inspector #138 received the information related to the self report on the admission package and further requested to review the home's admission package along with the Resident Contract Agreement.

The admission package, provided by Staff #103, was reviewed by LTCH Inspector #138 and it was noted by the inspector that the package did not contain a copy of the home's policy to promote zero tolerance of abuse and neglect of residents. The inspector spoke with Staff #103 who stated to the inspector that she is the staff member who reviews the admission packages with new residents and families and she stated that the home's admission package does not include the home's policy to promote zero tolerance of abuse and neglect of residents. Staff #103 further stated that the policy may be in the package that is given to people who come to the home for a tour. LTCH Inspector #138 spoke with Staff #133 who organizes the tours of the home and obtained the package of information given to those on tour. The inspector reviewed this package and noted that it did not contain a copy of the home's policy to promote zero tolerance of abuse and neglect of residents. [s. 78. (2) (c)]

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**WN #16: 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:**

**s. 79. (3) The required information for the purposes of subsections (1) and (2) is,**
**(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)**
**(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)**
**(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)**
**(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)**
**(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)**
**(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; 2007, c. 8, s. 79 (3)**
**(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; 2007, c. 8, s. 79 (3)**
**(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)**
**(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)**
**(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)**
**(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)**
**(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; 2007, c. 8, s. 79 (3)**
**(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; 2007, c. 8, s. 79 (3)**
**(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)**
**(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)**
**(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)**
**(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)**

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**Findings/Faits saillants :**

1. The Licensee failed to ensure that the required information in the Act section 79 (3) (c),(e), (f), (g), (n), and (o) is posted in accordance with section 79 (1) in a conspicuous and easily accessible location.

On September 29, 2014, LTCH Inspectors #545 and #126 conducted a tour of the home as this is a mandatory task of Stage 1 of the RQI. It was observed by both inspectors that multiple items that are required to be posted in the home were not posted at the time of the tour.

LTCH Inspector #138 conducted another tour of the home on October 3, 2014 and again on October 8, 2014 and observed that the following was not posted:

-the home's policy to promote zero tolerance of abuse and neglect of residents,
-the home's procedure for initiating complaints to the license,
-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,
-the most recent minutes of the Residents' Council minutes. The last posted minutes for Residents' Council was dated November 27, 2013 when the last available Resident' Council minutes for the home are March 3, 2014.
-the most recent minutes of the Family Council minutes as consented by the Family Council.

LTCH Inspector #138 spoke with the DOC on October 7, 2014, as directed by the home's Administrator, regarding the lack of posting of the above items. With respect to the home's abuse policy and the home's complaint process, the DOC stated that these are available on the home's website but stated that she would obtain copies along with all other items noted above and ensure that these items are posted. [s. 79. (3) (c)]

**WN #17: 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. The Licensee has failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On October 2, 2014, LTCH Inspector #126 interviewed nursing staff, Staff #101 and Staff #102 regarding non controlled drug destruction. Both staff indicated that on a daily basis the ward clerk would go in the medication room and pick up the discontinued medication and bring it downstairs to the pharmacy for destruction. LTCH Inspector #126 asked nursing staff if the Ward Clerk was a nurse, they indicated that she was but were unsure if she was still practicing.

On October 2, 2014, LTCH Inspector #126 interviewed the Ward clerk, Staff #103, who indicated that she is a Registered Practical Nurse but works at the home as a ward clerk. Staff #103 indicated that she collects the discontinued medications and takes them downstairs to the pharmacy. Staff #103 also stated that it is part of the ward clerk's responsibilities to preform this function and that her replacement when she is away from the home is required to do the same. Staff #103 stated that her replacement is not a registered nurse and confirmed that this person does have access to the medication room.

Discussion with nursing staff, Staff #101, indicated that people working in the ward clerk position do have access to the medication room. [s. 130. 2.]

**WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal**

**Specifically failed to comply with the following:**

**s. 136. (1) Every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of,**
**(a) all expired drugs; O. Reg. 79/10, s. 136 (1).**
**(b) all drugs with illegible labels; O. Reg. 79/10, s. 136 (1).**
**(c) all drugs that are in containers that do not meet the requirements for marking containers specified under subsection 156 (3) of the Drug and Pharmacies Regulation Act; and O. Reg. 79/10, s. 136 (1).**
**(d) a resident's drugs where,**
**(i) the prescriber attending the resident orders that the use of the drug be discontinued,**
**(ii) the resident dies, subject to obtaining the written approval of the person who has signed the medical certificate of death under the Vital Statistics Act or the resident's attending physician, or**
**(iii) the resident is discharged and the drugs prescribed for the resident are not sent with the resident under section 128. O. Reg. 79/10, s. 136 (1).**

**Findings/Faits saillants :**

1. The Licensee has failed to ensure that as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal.

On October 7, 2014, LTCH Inspector #126 interviewed the DOC regarding the policy of drug destruction and disposal. The DOC indicated that the home does not have a specific policy regarding drug destruction. The DOC discussed with pharmacy and provided LTCH Inspector #126 a copy of the pharmacy policy "Waste Management, Including hazardous waste: Chemical Pharmaceutical and Biomedical" Policy Number Admin 03, effective date 2001-10. This policy includes several section of waste management and one section related to pharmaceutical waste. The policy was reviewed and does not meet the legislative requirement of section 136 and does not include the following:
136 (1) Identification of drugs;
(2) destruction and disposal;
(3) composition of team acting together for drug destruction;
(4) record for controlled substance destruction and disposal by team;
(5) disposal and destruction system audited annually;
(6) drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

On October 8, 2014, LTCH Inspector #126 discussed the waste management policy with the DOC, she indicated that after herself reviewing the policy she was aware that the waste management policy was not meeting legislative requirements of section 136. [s. 136.]

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**WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.**

**Specifically failed to comply with the following:**

**s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:**
**1. The resident's ability under subsection 82 (2) of this Regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1). O. Reg. 79/10, s. 224 (1).**

**Findings/Faits saillants :**

1. The Licensee failed to ensure that the package of information provided for in section 78 of the Act includes the Resident's ability under section 82 (2) of the regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1).

During the RQI, the home is required to self report on its package of information, otherwise known as the admission package. LTCH Inspector #138 received information relating to the self report of the admission package and further requested to review the home's admission package along with the Resident Contract Agreement.

The admission package, provided by a ward clerk, Staff #103, was reviewed by LTCH Inspector #138 and it was noted by the inspector that both the admission package and the Admission Contract Agreement did not contain information related to the resident's ability to retain a physician or registered nurse in the extended class. The inspector spoke with Staff #103 who stated to the inspector that she is the staff member who reviews the admission package including the Resident Contract Agreement with new residents and families and she stated that the home's admission package only lists names of the home's physicians. [s. 224. (1) 1.]

**WN #20: 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. (12) The licensee shall ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunizations. O. Reg. 79/10, s. 229 (12).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with O.Reg 79/10 s. 229 (12) in that the home did not ensure that the all pets living in the home or visiting as part of a pet visitation program have up-to-date immunizations.

During an interview with Recreation Technician, Staff #129, she indicated that she was responsible to manage the Pet Visits program in the home. She indicated that many animals visit the home on a regular basis including:

-a volunteer from St-John Ambulance visits every Thursday with one dog, named Cashew.
-a volunteer from the Humane Society visits regularly, next visit to occur October 9, 2014. Staff #129 indicated that the volunteer usually brings dogs but sometimes brings a cat, and that these animals are owned by staff of the Humane Society
-family member of a resident visits weekly with a dog
-Staff #129's father visits weekly with her own dog Sam during the winter months when he is available to bring the dog for a 60-90 minute visit

Upon review of the home's Pet Visits policy, CLIN CARE 20 (revised 2013-02), it is documented that pets must be fully immunized and that vaccinations must be up-to-date.

Staff #129 indicated that as the person responsible for the Pet Visits program she is aware that all pets that visit the home must have up-to-date immunizations but she does not monitor or verify pet immunizations. [s. 229. (12)]

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**Issued on this 22nd day of October, 2014**

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

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

**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) :** | PAULA MACDONALD (138), ANGELE ALBERT-RITCHIE (545), LINDA HARKINS (126), LISA KLUKE (547) |
| **Inspection No. / No de l'inspection :** | 2014_362138_0014 |
| **Log No. / Registre no:** | O-000921-14 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Oct 21, 2014 |
| **Licensee / Titulaire de permis :** | BRUYERE CONTINUING CARE INC.<br>43 BRUYERE STREET, OTTAWA, ON, K1N-5C8 |
| **LTC Home / Foyer de SLD :** | ÉLISABETH-BRUYÈRE RESIDENCE<br>75 BRUYERE STREET, OTTAWA, ON, K1N-5C8 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Amy Porteous |

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

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

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

**Order / Ordre :**

The licensee shall ensure that all staff of the home, including those working in the home pursuant to a contract/agreement, receive, at a minimum, training on Residents' Bill of Rights and the home's policy to promote zero tolerance of abuse and neglect of residents.

**Grounds / Motifs :**

1. According to the Act section 76 (1), every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section which includes subsection 76 (2) 1 Residents' Bill of Rights and subsection 76 (2) 3 the long term care home's policy to promote zero tolerance of abuse and neglect of residents. According to the Act subsection 76 (4) every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. In accordance with the regulation section 219 (1), the retraining intervals for the purposes of subsection 76 (4) of the Act are annual intervals.

During resident and family interviews conducted as part of Stage 1 of the Resident Quality Inspection (RQI), several residents and a family member indicated to Long Term Care Homes (LTCH) Inspectors #545, #126, and #547 that they experienced incidents of not being treated with respect and dignity. As a result of these comments LTCH Inspector #545 interviewed staff about the training they received, specifically related to Residents' Bill of Rights and the home's policy to promote zero tolerance of abuse and neglect of residents as well as reviewed the home's mandatory training program with respect to the Act.

LTCH Inspector #545 spoke with a PCA, Staff #128, who indicated that she was

hired in the organization several years ago but that she had been working in the long-term care home for about a week. Staff #128 added that she had received her training on Residents' Bills of Rights and the prevention of abuse and neglect of residents however, upon review of the home's Employee Mandatory eLearning Report, it was documented that Staff #128 had not received training in these areas or any other training as outlined in the Act subsection 76 (2).

LTCH Inspector #545 spoke with another PCA, Staff #134, on October 8, 2014 who indicated that she was a casual employee recently employed at the home, adding that she accepted a position at the home during the restructuring in March 2014. Staff #134 indicated she had not received the home's mandatory training program as of yet, including training on Residents' Bill of Rights and the home's abuse and neglect policy. The DOC arrived during the discussion and informed Staff #134 that arrangements would be made to allow for the mandatory training.

LTCH Inspector #545 reviewed the home's Passport to Learning for Long-Term Care Staff (October 2013—January 2014), comprised of seven Modules, including Residents' Bill of Rights and the home's policy to promote zero tolerance of abuse and neglect of residents as well as other mandatory training as per legislation. It is described as follows:

- Module 1: Home Mission Statement, Residents' Bill of Rights, Whistleblowing Protection
- Module 2: Pleasurable Dining
- Module 3: Abuse and Neglect
- Module 4: Least Restraint, Last Resort
- Module 5: Protect Residents, Prevent Falls
- Module 6: Continence Care and Bowel Management
- Module 7: Preventing Pressure Ulcers in Long-Term Care

Further, LTCH Inspector #545 reviewed the home's Employees Mandatory E-Learning Report (dated: March 2013 to September 30, 2014) provided by the Administrative Assistant, Staff #133. It was documented that 28 out of 82 staff (registered nursing staff, PCA's and Meal Helpers) or 34% had not received Residents' Bill of Rights training and 29 out of 82 (35%) had not received the training of the long-term care home's policy to promote zero tolerance of abuse and neglect of residents. The inspector held a discussion with the DOC on October 8, 2014 regarding the training of staff and the DOC indicated that she

was aware that not all staff had received the home's mandatory training program, as per the Act, and had already made plans to follow-up with individual staff in one-on-one meetings.

Additionally, on October 6, 2014, LTCH Inspector #545 spoke with a contracted staff member, Staff #127, who indicated that employment commenced at the home three weeks ago and that Staff #127 had not received training on Resident's Bill of Rights, the home's abuse and neglect policy or any other mandatory training. A Meal Helper, Staff #131, indicated to the inspector that she was hired 18 months ago and was provided training on Residents' Bills of Rights and the home's abuse and neglect policy as part of her orientation but had not been requested to do any further retraining.

During a discussion with LTCH Inspector #138, a student, Staff #113, who indicated to LTCH Inspector #138 that she was provided an orientation when she started at the home but that she had not received training on the Residents' Bill of Rights or the home's abuse and neglect policy. A teacher for a local college who supervises student placements at the home, Staff #115, stated to LTCH Inspector #138 that she had not received training on the home's abuse and neglect policy nor has she received retraining on Residents' Bill of Rights or the home's abuse and neglect policy in the two years she has been at the home.

LTCH Inspector #545 spoke with the DOC on October 8, 2014 regarding the training needs according to the Act for students in the home. The DOC stated that the home's mandatory training program is not offered to students as students work with staff from the home who have already received the training. She also indicated that contract staff members such as the elevator guards who monitor the elevator on the dementia unit on the 6th floor had not been offered the home's mandatory training program before starting employment. The DOC added that the home expected the elevator guards to provide assistance to staff if required such as sitting between two residents to prevent conflict. She indicated as well that she would expect the elevator guards to report to the registered staff any observed suspicious activity.

During another interview with the DOC on October 9, 2014 she confirmed that PCA and RPN students participated in direct care to residents and worked in the home pursuant to a contract/agreement between the licensee and third party. The DOC explained that the colleges were responsible for providing mandatory

training as set out in the Act to the students prior to their clinical practicum in the home. The home was unable to demonstrate through the contracts that all mandatory training was provided to the students.
(545)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Dec 31, 2014

## 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 21st day of October, 2014**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** PAULA MACDONALD

**Service Area Office /**
**Bureau régional de services :** Ottawa Service Area Office