Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 31, Aug 1, 10, 13, 15, 17, 20, 21, 23, 24, 28, Sep 5, 11, 24, 25, 27, 28, Oct 1, 9, 10, 17, 18, 2012	2012_061129_0008	Complaint

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

THE VILLAGE OF SANDALWOOD PARK
425 Great Lakes Drive, BRAMPTON, ON, L6R-2W8

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

PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with residents, family members, registered and unregulated nursing staff, the Acting Director of Care, the Acting General Manager, RAI/MDS Coordinators and Quality Improvement Nurse.

During the course of the inspection, the inspector(s) observed residents, reviewed clinical record documents and reviewed home records including written complaints and the homes policies and procedures in relation to Log #H-002567-11,H-001066-12, H-001497-12, H-002574-11 and H-00131-12.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

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

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

Findings/Faits saillants :

1. The licensee did not ensure that every resident's right to be protected from abuse was fully respected and promoted in relation to the following: [3(1)2]
a) Resident #8's right to be protected from abuse was not fully respected or promoted when the resident was sexually abused by a co-resident. Staff and documentation confirmed the incident occurred. An internal incident report completed by staff in the home indicated that on assessment resident #8 was clearly upset and crying. Care needs identified for Resident #8's in the plan of care indicated that the resident would not have been able to consent to sexual touching.
b) Resident #6's right to be protected from abuse was not fully respected or promoted when the resident was physically and emotionally abused by a co-resident. Staff confirmed and it is documented in resident #6's clinical record that this resident was threatened with physical violence by a co-resident and was struck by this same co-resident on 5 occasions . Resident #6 confirmed that he was fearful of this co-resident.
(PLEASE NOTE:This evidence was found during inspection #2012_061129_0010)
2. The licensee did not ensure that every resident's right to be afforded privacy in treatment and in caring for his or her personal needs was fully respected and promoted, in relation to the following: [3(1)8]

Resident #3's privacy was not respected or promoted in relation to the following:
a) A contracted technical service provider confirmed that resident # 3's privacy was not respected when video tape of the resident was viewed in excess of the time required to ensure the camera equipment was operational. The contracted technical service provider disclosed to the family that video of the resident was viewed over an expended period of time.
b) A staff person from a out of home contracted service supplier was provided with personal information about the resident's bowel and bladder functions, habits and responsive behaviours in relation to the provision of personal care, in order to identify supplies needed by the home. The resident's power of attorney indicated that she was not asked nor did she consent to having this information about the personal habits of the resident shared with persons other than caregivers.
3. The licensee did not ensure that every resident's right to be to be properly sheltered , fed, clothed , groomed and cared for in a manner consistent with his or her needs was fully respected and promoted, in relation to the following: [3 (1) 4]
Resident #3's right to be cared for in a manner consistent with the identified needs was not fully respected and promoted when staff in the home did not provided care identified as required to resident #3. Staff confirmed and it is documented in the shift reports as well as the resident's clinical record that the resident refused to have needed personal care provided during an evening shift. Staff working the following night shift took no action in order to provide the resident with the required care and there was no documentation in the clinical record that indicated staff working nights checked the resident. Staff working the following day shift reported finding the resident heavy soiled with both urine and feces. Registered staff reported these events to family who visited the resident that morning, and who were so upset by these events they forwarded a letter to the General Manager commenting on how humiliated the resident must have felt to be found in bed, soaked and soiled from head to foot and how terrible it must have been for the resident to lie in bed in such a condition, not being able to get up and having to breathe in that very strong, acrid smell all night.
4. The licensee did not ensure that every resident's 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 was fully respected and promoted, in relation to the following: [3(1)1]
Staff in the home did not treat resident #3 with courtesy and respect and in a way that fully recognized the resident's individuality in relation to the following:
-Staff confirmed and it is documented in the clinical record that staff forced the resident to receive non urgent care on 6 occasions over a two month period of time. It was documented that the resident was demonstrating opposition to this care being provided by yelling at staff to stop, hitting staff as well as attempting to punch and kick staff. Staff and the documentation confirmed that care was provided to the resident on these occasions despite the resident demonstrating these responsive behaviours.
-Staff in the home were aware of personal challenges resident #3 had in the provision of personal care through a booklet that family provided to the home when the resident was admitted and that was placed in the resident's care binder. Information provided served to introduce the staff to the resident's needs and approaches that had been successful while family were providing care to the resident at home. Information provided in this booklet included explanations regarding the resident's need to have privacy during personal care, suggested approaches for staff that would assist in overcoming the resident's communication issues, that the resident had recurring nightmares, as well as information about the resident's past and memories.

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 by ensuring that resident rights 3(1) 1, 3(1)2, 3(1)4 and 3(1)8 are fully respected and promoted, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

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

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the plan of care for resident #3 was provided as specified in the plan of care, with respect to the following: [6(7)]
Staff in the home did not ensure that the care was provided to resident #3 as set out in the plan of care, when the resident was forced to receive care despite becoming upset and demonstrating responsive behaviours on 5 occasions. The resident's plan of care directs staff to provide the resident with a wet cloth to wash private areas as the resident gets upset when staff try to do this, staff are to ask the resident to allow them to help and to not force the resident to accept their help. Staff did not provide the care identified in the plan of care in June 2012 when it is documented that personal care was provided to the resident while she was resistive and yelling at staff, on a second occasion in June 2012 when it is documented that the resident became aggressive and angry while staff were providing evening care and that the resident was hitting staff during the provision of care, in July 2012, when it is documented that staff showered the resident despite the resident yelling and punching at staff the entire time, on a second occasion in July 2012 when it is documented that the resident became verbally and physically aggressive when staff removed the resident's pants and the resident continued to be aggressive throughout the entire task and in August 2012 when it is documented that while personal care was being provided the resident began to kick and hit out as well as yell at staff during the provision of care. Staff confirmed that care provided on the above noted dates was not consistent with the directions for care in the plan of care for this resident.
2. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised when the care set out in the plan was not effective, in relation to the following: [6(10)(c)]
Resident #4's plan of care was not reviewed or revised when care goals to have the resident not exhibit responsive behaviours and that episodes of responsive behaviours would be reduced, were not met. Over a three month period of time in 2012 staff documented 374 episodes of responsive behaviours that included verbal abuse, physical abuse and socially inappropriate behaviour.
The Minimum Data Set (MDS) assessment completed during this period of time indicated that there were no changes in the resident's behavioural status compared to 90 days previously and the Resident Assessment Protocol(RAP) assessment completed following the MDS assessment indicated that the home will continue with the current plan of care and that the care plans have been reviewed and are ongoing. Staff confirmed that the plan of care for the resident was not revised when the documentation indicated that the resident continued to demonstrate responsive behaviours and the goals of care and corresponding interventions for care were not effective in managing the responsive behaviours being demonstrated by this resident.
3. The licensee did not ensure that the resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care, with respect to the following: [6(5)]
Resident # 3 was identified as not being able to make decisions in relation to complex care issues. A family member who has power of attorney acts on behalf of the resident as the substitute decision maker (SDM). The resident's SDM indicated she was not given the opportunity to participate in the development and implementation of care related to changes in shower times, changes in medications and diagnostic procedures.
• The SDM was not part of a decision to change the resident's shower time and spoke with the Director of Care (DOC), questioning why the resident's shower schedule had been changed from the morning to the evening, particularly in light of the resident's long time personal habits and responsive behaviour issues related to the provision of personal care. The DOC at that time indicated that they would try to switch the resident back to the morning shower schedule. The resident's substitute decision maker confirmed that she was not consulted when the bath schedule was changed and at the time of this inspection the resident continued to be showered in the evening.
• The clinical record confirms that in April 2010 a new medication was ordered for the resident. The resident's SDM confirmed that she became aware of this medication when she received the invoice from the home's pharmacy provider. The DOC indicated that staff document when they obtain consent for changes in medications and treatments in the resident's electronic progress notes and and confirmed that there was no indication that the resident's SDM had been made aware of this medication or provided consent for it to be administered.
• In February 2011 the SDM became aware of a change in medication, through a review of the invoice provided by the pharmacy provider. An medication that had been prescribed for the resident had been discontinued. The SDM indicated she became very concerned about this change because the resident had been on this medication prior to being admitted to the home and it was effective in managing some night time behaviours and confirmed that she was not part of the decision to change this treatment plan. There was no documentation in the clinical record that indicated the SDM was part of a discussion about the discontinuation of this medication.
• The resident's physician wrote an order in September 2011 to increase a medication the resident was receiving from 12.5mg to 25mg. The resident's SDM confirmed that she was not made aware of this change in medication and did not

give consent for this change in medication. Documentation in the clinical record does not indicate that the resident's SDM was contacted or gave consent for this change in medication.
• The resident's physician wrote an order in March 2012 to hold an medication the resident had been receiving. The resident's SDM confirmed that she was not contacted about this change in the resident's medication nor did she give consent for this change. Documentation in the clinical record does not indicate that the resident's SDM was contacted or gave consent for this change in medication.
• The resident's SDM expressed concern that she had not participated in the decision to have the resident receive with two diagnostic procedures in August 2012. Two diagnostic procedures were performed on the resident. The DOC confirmed that the SDM was not informed nor was consent obtained prior to the examinations being performed.

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 by ensuring that the care set out in the plan of care is provided to the resident (6(7))and that the resident is reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective (6(10)(c)), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following subsections:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee did not immediately forward all written complaints concerning the care of a resident or the operation of the home to the Director, with respect to the following: [22(1)]
The General Manager confirmed:
a) An email sent by resident #11's family member to the Director of Nursing and received by the Quality Improvement Nurse, contained a complaint regarding an incident involving the resident being attacked by another resident and was not immediately forwarded to the Director.
b) An email sent by resident #10's family member to the Director of Nursing and received by the Quality Improvement Nurse, contained a complaint regarding concerns about care for the resident and was not immediately forwarded to the Director.
c) An email sent by resident #12's family and received by the Quality Improvement Nurse, contained a complaint regarding the resident not receiving care and was not immediately forwarded to the Director.
d) An email sent by resident #3's family to the General Manager contained a complaint regarding the care being provided to a resident and negative interactions with staff and was not forwarded immediately to the Director.

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 by ensuring that all written complaints concerning the care of a resident or the operation of the home are immediately forwarded to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. Management staff in the home, who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or the risk of harm to the resident did not immediately report the suspicion and the information upon which it was based to the Director, with respect to the following: [24(1) 2]
a) The General Manager confirmed that he suspected a resident may have been abused when he received an email sent by a family member of a resident #3 outlining a situation where care being provided was not appropritate, however this suspicion and the information on which the suspicion was based was not immediately forwarded to the Director.
b)The General manager confirmed that he suspected a resident may have been neglected by the staff when he received an email sent by a family member of resident #3 outlining a situation were the resident required care that was not provided for an extended period of time. The General manager confirmed this suspicion and the information on which the suspicion was based was not immediately forwarded to the Director.
c) The General Manager confirmed that he suspected a resident may have been abused when a report made by staff indicated a co-resident had inappropriate sexual contact with resident #8, who would have been unable to consent to such actions, however this suspicion and the information upon which it was based was not immediately reported to the Director.
d)The General Manager confirmed that he suspected that a resident may have been abused when he received an email from a resident's family that alleged the resident had been attacked by a co-resident, however this suspicion and the information upon which it was based was not immediately provided to the Director.
e)Staff did not immediately report a suspicion that abuse had occurred between residents #4 and #8. The home submitted a report to the Director through the Mandatory Critical Incident System (MCIS) a day following the incident. The General Manager confirmed that staff did not access the Ministry of Health's after hours paging system on December 26, 2011 to report this incident.
f)Staff did not immediately report a suspicion that abuse had occurred between residents #5 and #6. The home submitted a report to the Director through the MCIS a day following the incident. The General Manager confirmed that staff in the home did not access the Ministry of Health's after hours paging at the time of the incident.
(PLEASE NOTE:This evidence of non-compliance was found during inspection # 2012_061129_0010)
g)Staff did not immediately report a suspicion that abuse had occurred between two residents . The home submitted a report to the Director through the MCIS a day following the incident. The General Manager confirmed that staff in the home did not access the Ministry of Health's after hours paging at the time of the incident.
(PLEASE NOTE:This evidence of non-compliance was found during inspection # 2012_061129_0010)

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 by ensuring that a person who has reasonable ground to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident shall be immediately reported to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee did not ensure that where the Act or Regulations requires the licensee of a long term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure , strategy or system was implemented in accordance with all applicable requirements under the Act, with respect to the following: [8(1)(a)]

The licensee did not implement an organized interdisciplinary program with a restorative care philosophy in accordance with section 9(1) of the Act. Administrative staff in the home provided a policy identified as a Program for Active Living (Tab R-01) dated January 28, 2008 and indicated this was their restorative care program. This policy identified that a referral can be made for nursing rehabilitation programs. The General Manager confirmed that the nursing rehabilitation program included in the Program for Active Living has not been implemented and nursing rehabilitation programs were not available for resident's #3, #4 and #7 who may have benefited from specific programs included in the nursing rehabilitation program.
(PLEASE NOTE: Evidence related to resident #7 was found during inspection # 2012_061129_0010)

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 and ensuring that where the Act or the Regulation requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system that it is in compliance and implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee did not ensure that residents were provided with a range of continence care products that were based on their individual assessed needs, promote resident comfort, ease of use, dignity and promote continued independence wherever possible, in relation to the following: [51(2)(h)(i)(iii)(iv)]
The licensee did not provide resident #3 with continence care products that met the resident's assessed needs and the resident's family were purchasing and supplying incontinent care products for use by the resident. Staff confirmed and it is documented that the resident often refuses personal care, demonstrates responsive behaviours when this care is provided and staff identify the following care needs of resident #3:
- the resident will remain continent of urine with a regular toileting routine,
- staff are to ask the resident if they can assist with care,
- staff are to allow the resident to be as independent as possible in relation to urinary continence,
- that the resident is a very private person in relation to the provision of personal care,
-if assistance is required staff are to ask the resident to allow them to assist and staff are not to assist the resident before the resident attempts the activity.
Based on these factors and with input from the resident's Power of Attorney (POA) it was determined that the type of product best suited for this resident's physical and behavioural care needs was a pull-up type product. The POA was told by staff in the home that the use of pull-up products was limited to one product in a 24 hour period, which would not be sufficient for the resident and as a result the resident's the family have been purchasing these products.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following subsections:

s. 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. 2007, c. 8, s. 76. (4).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee did not ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, annual training in behaviour management in accordance with section 221(2)(1) of the Regulations, with respect to the following: [76(7)3]
Training information provided by the home indicated that 33 of 179 staff who provide direct care to residents received training in the area of behaviour management in 2011. The General Manager confirmed that the home has not implemented a monitoring system to ensure that staff providing direct care to residents who have not attended training programs are monitored to ensure that subsequent training programs are provided to these staff persons.
2. The licensee did not ensure that persons who have received training in the areas of the Resident's Bill of Rights and the home's policy to promote zero tolerance of abuse and neglect, under section 76(2) of the Act received annual retraining in accordance with section 219(1) of the Regulations, in relation to the following: [76(4)]
a) All staff in the home did not receive annual retraining in accordance with section 219(1) of the Regulations, in the area of the Resident's Bill of Rights. Training information provided by the home indicated that 108 of 179 staff received training in the area of the Resident's Bill of Rights in 2011.
b) All staff in the home did not receive annual training in accordance with section 219(1) of the Regulations, in the area of the long-term care home's policy to promote zero tolerance of abuse and neglect of residents. Training information provided by the home indicated that 91 of 179 staff received training in the area of the home's policy to promote zero tolerance of abuse and neglect of residents in 2011.
c) The General Manager confirmed that the home has not implemented a system to monitor staff who have not received the required annual retraining in order to ensure that training programs are provided to those staff who did not attend the training programs offered by the home.

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 all staff who provide direct care to the residents receive annual training in behaviour management and that all staff receive annual retraining in the Resident's Bill of Rights and the home's policy to promote zero tolerance of abuse and neglect, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the written policy in place to promote zero tolerance of abuse and neglect contained an explanation of the duty under section 24 to make mandatory reports, with respect to the following: [20(2)(d)]
The General Manager confirmed that an explanation of the duty under section 24 to make mandatory reports was not included in the home's policy [Resident Abuse] identified as tab 04-06 last reviewed in July 2011.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee did not ensure required information was posted in the home, in a conspicuous and easily accessible location, in relation to the following: [79(3)(e)]
A tour of the home was conducted on August 10, 2012 and the home's procedure for initiating complaints to the licensee was not posted. This was confirmed by the Acting Director of Care (ADOC).

Issued on this 18th day of October, 2012

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