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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 20, 2014	2014_211106_0010	S-000210-14	Resident Quality Inspection

Licensee/Titulaire de permis

SIOUX LOOKOUT MENO-YA-WIN HEALTH CENTRE
Fifth Avenue South, PO Box 909, SIOUX LOOKOUT, ON, P8T-1B4

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

WILLIAM A. "BILL" GEORGE EXTENDED CARE FACILITY
75 FIFTH AVENUE, SIOUX LOOKOUT, ON, P8T-1K9

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

MARGOT BURNS-PROUTY (106), LINDSAY DYRDA (575)

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): May 26, 27, 28, 29, 30, June 2, 3, 4, 5, 2014

The following Logs were reviewed as part of this inspection: Log# S-000210-14, S-000404-13

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), RAI Coordinator, Activation Coordinator, Registered Nursing Staff, Personal Support Workers, Family Members and Residents.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed the health care records for several residents, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Quality Improvement
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Snack Observation
Trust Accounts

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On June 3, 2014, inspector #575 reviewed the current care plan document for resident #772. The care plan document indicates staff are to monitor and record urine output daily.

On June 3, 2014, inspector #575 reviewed the urinary output sheets and progress notes for resident #772 and noted that the output was not recorded daily. On June 3, 2014 inspector #575 interviewed staff member #S-100 regarding resident #772. The staff member stated that the urinary output is not always recorded.

On June 3, 2014, inspector #575 interviewed the DOC regarding the Continence Care and Bowel Management Program. The DOC stated that the home does not currently have a formal Continence Care and Bowel Management Program. The licensee failed to ensure that the organized program required under section 48 of the Regulation, specifically the Continence Care and Bowel Management Program, that there is a written description of the program that includes its goals and objectives, relevant policies, procedures, and protocols, methods to reduce risk, outcomes monitoring, and protocols for referral of residents to specialized resources where required. [s. 30. (1) 1.]

2. Inspector #575 determined that resident #765's plan of care, in regards to nutritional requirements, does not provide clear directions to staff. On June 4, 2014 inspector #575 interviewed the DOC regarding the Nutrition Care, Dietary Services and Hydration Program in the home. The DOC indicated that the home does not have a formal Nutrition and Hydration Program.

The licensee failed to ensure that for the organized program required under section 11 of the Act, that there is a written description of the Nutrition Care, Dietary Services and Hydration Program that includes its goals and objectives, relevant policies, procedures, protocols, provides methods to reduce risk, methods to monitor outcomes, and protocols for referral of resident to specialized resources where required. [s. 30. (1) 1.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On May 29, 2014, inspector #575 reviewed the most recent care plan for resident #771 dated November 4, 2013. The care plan indicates that bed rails are used for bed mobility or transfer and that the resident requires bed rails up when in bed and call bell in reach at all times as resident may attempt to transfer self on own. The Health Care Record (HCR) for resident #771 was reviewed and no evidenced based assessment of the resident's bed rails or bed system was found. [s. 15. (1) (a)]

2. Resident #572's plan of care was reviewed by the inspector and it indicates the use of bed rails when the resident is in bed. Staff member #S-101 reported to the inspector that the resident will become agitated if staff do not apply the bed rails when they are in bed. The HCR for resident #752 was reviewed and no evidenced based assessment of the resident's bed rails or bed system was found. [s. 15. (1) (a)]

3. The "Side Rails Release Form", signed by resident #768's power of Attorney (POA) was reviewed by inspector #106. The form indicated that side rails are to remain down for resident #768. The plan of care for resident #768 was reviewed and it indicated, bed rails used for bed mobility or transfer for resident #768. On May 28, 2014, the inspector observed the bed rails of resident's #768's bed in the up position and on June 4, 2014, bed rails were again observed in the up position. The HCR for resident #768 was reviewed and no evidenced based assessment of the resident's bed rails or bed system was found.

On May 29, 2014, inspector #575 interviewed the DOC regarding bed rail assessments. The DOC stated that the home does not complete a specific bed rail assessment using evidence-based practice and that the use of bed rails are determined by staff through their own clinical judgment. The licensee failed to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident. [s. 15. (1) (a)]

Additional Required Actions:

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

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

Findings/Faits saillants :

1. On May 27, 2014 at approximately 1130 hrs inspector #575 observed resident #771 sitting in a wheelchair visibly wet with a urinal beside resident on a table. The resident's room was malodourous. At approximately 1200 hrs, inspector #575 observed resident #771 in the dining area for lunch. The resident was wearing the same pants and remained wet.

On June 2, 2014, inspector #575 observed the following in resident #771's room. At 1130 hrs inspector #575 noted the resident's urinal on the floor in front of the resident's wheelchair and a puddle of urine on the floor. At 1200 hrs the resident was in the dining area and the urinal remained on the floor in the resident's room with the puddle of urine. At 1500 hrs, the resident was in bed and the urine remained on the floor and the urinal was now at the bedside. The resident's floor was sticky.

On June 4, 2014 inspector #575 observed resident #771 sitting in the hallway. The resident's clothing was visibly stained.

On June 5, inspector #575 reviewed the care plan for resident #771. The care plan indicated that staff are to frequently check resident and ensure they are dry, comfortable and free from odour. Additionally, the care plan noted that, resident #771 requires extensive assistance for dressing, toileting, and personal hygiene. The care plan also indicates that staff are to request housekeeping to clean up areas when the resident is incontinent and keep the area clean and free from odour.

The licensee did not fully respect and promote resident #771's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs [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 that resident #771's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs is fully respected and promoted, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector #106 reviewed the HCR for resident # 752 was reviewed with a focus on oral care. It was found that the resident was completely dependent on staff for their oral care needs and required staff assistance in the am and pm. The resident flow sheet for resident #752 from May 15 to 28, 2014, was reviewed and there was no documentation to indicate the resident received personal care hygiene (which includes teeth brushing) on the following shifts:

-Days: May 15, 16, 2014
-Nights: May 15-18, 22, 2014 [s. 34. (1) (a)]

2. On June 4, 2014, inspector #575 reviewed resident #765's plan of care regarding oral hygiene. The plan of care indicated that resident #765 is totally dependent on staff to perform personal hygiene. Inspector #575 reviewed a dental consultation report that indicated resident #765 has dental concerns due to poor oral hygiene.

On June 4, 2014, inspector #575 interviewed staff member #S-103 regarding the oral hygiene routine for resident #765. The staff member indicated that the resident receives oral care in the morning, after lunch, and in the evening. The staff member confirmed that when oral hygiene is completed it is indicated on the flow sheet.

On June 4, 2014, inspector #575 reviewed the resident #765's flow sheets from March 31 to June 2, 2014. Documentation indicates that the resident did not receive personal hygiene (including oral care) occurred on the following day shifts:
-Days: March 31, April 1, 2, 5, 2014
-Nights: March 31,2014; April 1-7, 9, 12-30, 2014; May 1, 8, 10, 12, 13, 15-31, 2014; June 2, 2014. [s. 34. (1) (a)]

3. The HCR for resident #768 was reviewed by inspector #106, it was found that the resident is fully dependent on staff to provide oral care in the am and pm. The "Resident Flow Sheets" from April 7 to May 28, 2014, were reviewed and "Personal Hygiene" (which includes oral care. Documentation indicates that resident # 768 did not receive oral care on the following shifts:

-Days: April 20, 29, 2014; May 2, 2014
-Nights: April 7-20, 23-29, 2014; May 1-13, 20, 22-24, 26, 27, 29, 2014 [s. 34. (1) (a)]

4. On June 2, 2014, inspector #575 reviewed resident #754's plan of care regarding oral hygiene. The plan of care indicated that resident #754 requires extensive assistance for personal hygiene. Staff are to provide oral care each morning, evening and after meals. On June 2, 2014 inspector #575 reviewed resident #754's oral assessment which indicated that the resident had oral concerns.

On June 4, 2014, inspector #575 interviewed staff member #S-103 regarding the oral hygiene. The staff member confirmed that when oral hygiene is completed it is indicated on the flow sheet.

On June 5, 2014, inspector #575 reviewed the resident's flow sheets from April 2 to June 1, 2014. No personal hygiene (including oral care) was documented as having occurred on the following shifts:

-Days: April 18, 19, 2014; May 15, 19, 23, 2014
-Nights: April 8, 12-16, 18-20, 22-24, 30, 2014; May 1, 8, 10, 12-19, 21-28, 2014 [s.

34. (1) (a)]

5. On May 8, 2014, inspector #575 reviewed the most recent MDS assessment and the most recent care plan for resident #761. The MDS assessment indicated that the resident has dental concerns and is dependent on staff for personal hygiene. Interventions on the resident's care plan indicate that daily oral care is required. On June 5, 2014, the flow sheets were reviewed for resident #761 from April 2 to May 19, 2014. Inspector #575 noted that personal hygiene (including oral care) was not completed on the following shifts according to documentation:

-Days: April 23, 2014, May 18, 2014
-Nights: April 2-30, 2014 May 1-13, 15-19, 2014 [s. 34. (1) (a)]

6. The health care record for resident #755 was reviewed and it indicated that the resident is fully dependent on staff to provide oral care. The "Flow Sheets" for resident #755 were reviewed and they indicated that "Personal Hygiene" that includes oral care was not provided during the following shifts:

-Days: April 10, 2014; May 7, 15, 19, 2014
-Nights: April 3-25, 27-30, 2014; May 1, 8, 10-29, 2014

On June 4, 2014, inspector #575 interviewed staff member #S-103 regarding the oral hygiene. The staff member confirmed that when oral hygiene is completed it is indicated on the flow sheet. The licensee failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, mouth care in the morning and evening, including the cleaning of dentures, specifically residents # 752, #765, #768, #754, #761, #755. [s. 34. (1) (a)]

7. Resident #761 was triggered by MDS data oral/dental problems. On June 2, 2014, inspector #575 reviewed resident #761's plan of care and documentation of an offer of an annual dental assessment was not found. [s. 34. (1) (c)]

8. Resident #754 was triggered by MDS data oral/dental problems. On June 2, 2014, inspector #575 reviewed resident #754's plan of care and documentation of an offer of an annual dental assessment was not found. [s. 34. (1) (c)]

9. Resident #771 was triggered by MDS data oral/dental problems and through the resident interview dental care lacking. On June 2, 2014, inspector #575 reviewed

resident #771's plan of care and documentation of an offer of an annual dental assessment was not found. [s. 34. (1) (c)]

10. On May 27, 2014, during stage 1 family interview, resident # 768's POA reported that the resident had told them that they had an oral concern. Inspector 106 reviewed the "Oral Health Assessment Tool (OHAT) for Long-Term Care", which indicated that the resident should be referred for further dental assessment.

On June 4, 2014, staff member #S-104 reported that referrals are documented in progress notes, MD orders, or in the RPN binder under the individual resident or clipped to the front of the binder. The staff member also told the inspector if a resident needs a dental referral they will tell the RAI Coordinator and they will schedule the assessment.

The inspector reviewed the resident's Health Care Record, focusing in the areas specified by staff member #S-104 to find an dental referral as well as interviewed the RAI Coordinator and documentation of an offer of an annual dental assessment was not found. [s. 34. (1) (c)]

11. The RAI MDS Assessment for resident #763, was reviewed by inspector 106 and it indicates the resident has dental concerns. The "Oral Health Assessment Tool (OHAT) for Long-Term Care for resident #763, was reviewed and it indicates the resident was to be referred to a dental professional. The resident's Health Care Record was reviewed and no referral to a dental professional was found.

Inspector #106 reviewed the "Oral Health Assessment Tool (OHAT) for Long-Term Care", for resident #755, it indicated that the resident required a referral to an oral care professional. The inspector asked staff member #S-101 if resident #775 or #763 had an oral care referral and they stated" no". [s. 34. (1) (c)]

12. On May 30, 2014 inspector #575 interviewed the DOC regarding whether the home offers residents an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the SDM if payment is required. The DOC indicated that dental care and dental assessments are not routinely offered to residents in the home.

The licensee failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, an offer of an annual dental

assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required, specifically for residents # 761, #754, #771, #768, #763, #755. [s. 34. (1) (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 each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, mouth care in the morning and evening, including the cleaning of dentures, specifically in regards to residents # 755, #761, #754, #768, #765, and #752; and an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required, specifically in regards to residents # 755, #763, #768, #771, #754, and #761, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. On June 2, 2014, inspector #106 asked staff member #S-105, why resident #572 was on a medication, the staff member stated that they were on that medication for a specific medical, but they were unable to provide documentation to support this claim. [s. 53. (3) (a)]

2. Resident #771 was triggered by census review for use of a specific medication. On June 2, 2014 inspector #575 reviewed resident #771's plan of care and could not find documentation of assessments for responsive behaviours. [s. 53. (3) (a)]

3. On June 2, 2014, inspector #106 asked staff member #S-105, why resident #568 was on a medication, the staff member stated that they were on that medication for "behaviours". The RAI MDS assessment was reviewed by inspector #106 and no diagnosis that would support the use of the medication was found.

On May 30, 2014, inspector #575 interviewed the DOC regarding the home's Responsive Behaviour Program. It was found that the home does not currently have a Responsive Behaviour Program and the DOC is currently working on creating a Responsive Behaviours Program. There are no completed procedures or policies for staff to refer to regarding responsive behaviours on how to manage, assess, reassess and monitor residents who have responsive behaviours. The licensee failed to ensure that a Responsive Behaviour Program is developed and implemented in accordance with evidence-based practices. [s. 53. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a Responsive Behaviour Program is developed and implemented in accordance with evidence-based practices, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. On June 5, 2014, at 1347hr inspector noted resident #773 eating in a sandwich, pudding and juice while sitting in a chair across from the nursing station. No staff were in attendance to monitor the resident. At approximately 1350hrs the inspector asked registered staff member #S-106 who was currently monitoring the residents that were eating, they asked the inspector "are there residents eating?". The inspector gestured towards resident #773 and the staff member said they did not know who was monitoring the resident.

The registered staff member #S-106 then left the area to answer a call bell that had begun to ring, leaving the resident to eat their meal without supervision. At 1402hrs, another RPN walked by the resident, went into the lounge area, collected a different resident and on the way to the second resident's room, asked resident #773 how their lunch was and provided encouragement by indicating they still had another juice to finish.

The resident appeared to be finished eating their meal at approximately 1407hrs and at 1421hrs the resident was observed to drink the last of the juice that they had in front of them. From 1347hrs to 1421hrs, the resident was not being monitored by any staff member, as multiple staff members were observed to quickly walk by and leave the area where the resident was eating, while preforming other tasks. [s. 73. (1) 4.]

2. On June 5, 2014, at approximately 0815hrs, inspector #575 observed residents #752, #754, #771 in the dining area with no staff members present. All residents had beverages and were unsupervised. Resident's were unsupervised for approximately 10 minutes.

The licensee failed to ensure the home has a dining and snack service that includes, at a minimum, the following elements: Monitoring of all residents during meals. [s. 73. (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 the home has a dining and snack service that includes, at a minimum, the following elements: Monitoring of all residents during meals, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. On May 27, 2014 the DOC provided the inspector with the completed, "LTCH Licensee Confirmation Checklist - Quality Improvement". On June 3, 2014, the inspector conducted an interview with the DOC to determine if an annual satisfaction was being taken of residents and families. During the interview, the DOC told the inspector that the home has not conducted annual satisfaction surveys. The licensee failed to ensure that at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. [s. 85. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home, to be implemented voluntarily.

WN #8: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. On May 30, 2014 inspector #575 reviewed the immunization records for resident's #752, #754, and #772. The inspector noted that there was no documentation regarding tuberculosis screening for resident's #754 and #772. Documentation for tuberculosis screening was incomplete for resident #752.

On June 2, 2014, inspector #575 interviewed the Infection Control staff member who confirmed that there was no documentation regarding tuberculosis screening for resident's #752 or #772. The staff member provided documentation of tuberculosis screening for resident #754 that was completed in 2007 however the resident was admitted to the home in 2008.

The licensee did not ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. [s. 229. (10) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that each resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee, to be implemented voluntarily.

WN #9: 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. (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).

Findings/Faits saillants :

1. On May 29, 2014, inspector #575 reviewed the plan of care for resident #765 regarding nutrition and hydration. The resident's current care plan and Nutritional Re-Assessment form, provide different instructions, additionally the hydrating requirements for the resident are unclear.

On June 4, 2014 inspector #575 interviewed staff member #S-104, was unsure and

unable to find the orders regarding the resident's hydration requirements. The licensee did not ensure that resident #765's plan of care set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The "Side Rails Release Form" signed by resident # 768's, power of Attorney (POA) was reviewed by inspector #106. The form indicated that side rails are to remain down for resident #768.

The RAI MDS assessment for resident #768 indicates that bed rails are used for bed mobility or transfer. The care plan document in the section titled, "Transferring", indicates "Bed rails used for bed mobility or transfer", this document does not state what rails are to be used.

Inspector 106 observed resident # 768's bed on May 28, 2014 and the 2 top side rails were in the up position and on June 3, 2014, 2 side rails against the wall were in the up position. By not following the POA's direction to keep the bed rails in the down position, the licensee failed to 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. [s. 6. (5)]

3. On May 27, 2014, during a stage 1 family interview, the POA for resident # 768 told inspector 106 that they were not informed of a change of medication, prior to it being initiated. The inspector reviewed the "Physician's Order Sheet" for resident #768 and found that the resident had an increase in a medication in March 2014. On June 4, 2014, inspector 106 asked registered staff member # S-104, where they would document informing a POA of a change to medications. Staff member #S-104 did not know, they stated that they only work at the home casually and this is the 1st time that they have been a team lead. Staff member S-104 stated that they were unsure if it was even part of the home's process to notify POA of a change in medication.

On June 4, 2014, the inspector asked the DOC what the expectation is regarding informing POA's of a medication change, they stated that staff are expected to contact the POA and document in the progress notes that they had informed them of the change of medication. If the staff member was unable to get a hold of the POA then they would document in the progress notes that they were unable to contact the POA . Progress notes for resident # 768 from February 14 to the last entry dated May 9, 2014, and no note indicating staff had contacted the POA to inform them of the

change in medication was found.

The licensee failed to 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. [s. 6. (5)]

4. On June 3, 2014, inspector #575 reviewed the current care plan for resident #772. The care plan indicates that the resident has a urinary device and staff are to monitor and record urine output daily. According to staff member #S-101, urine output is recorded on the urinary output sheets or in progress notes.

On June 3, 2014, inspector #575 completed an audit of the urinary output records and the progress notes for the last 3 months for resident #772. During the month of March 2014, urinary output was recorded 0/31 for day shift and 2/31 or 6.5% on night shift. During the month of April 2014, urinary output was recorded 5/30 or 16.7% on day shift and 9/30 or 30% on night shift. During the month of May 2014, urinary output was recorded 2/31 or 6.5% on day shift and 10/31 or 32.3% on night shift.

On June 3, 2014, inspector #575 interviewed staff member #S-100 regarding resident #772. The staff member stated that the urinary output is not always recorded. The staff member further stated that the urinary output is only recorded if the resident's output is low.

The licensee did not ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

5. On May 29, 2014, inspector #575 reviewed the most recent care plan for resident #771 dated November 4, 2013. The care plan indicates that specific bed rails are used for bed mobility or transfer and that the resident requires bed rails up when in bed and call bell in reach at all times as resident may attempt to transfer self on own.

On May 30, 2014, at approximately 1430hrs, June 2, 2014 at approximately 1500hrs, and June 3, 2014 at approximately 1040hrs, inspector #575 observed resident #771 in bed with bed rails not indicated in their plan of care in the up position.

On June 3, 2014, inspector #575 interviewed staff member S-100 regarding bed rails for resident #771. The staff member indicated that the resident's care plan states they

requires specific bed rails up when in bed, however the resident likes to have bed rails not indicated in the plan in the up position. The staff member stated that the bed rails are used for safety. The staff member indicated that if a resident requests certian bed rails up the staff are not required to complete a restraint record because it is not considered a restraint when resident's ask.

The licensee did not ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

6. All days during this inspection resident #755 was observed wearing homemade knitted slippers. The Health Care Record for resident #755 was reviewed and it indicated that the resident is fully dependent on staff for dressing and staff are to ensure the resident is wearing non-slip well-fitting shoes. The care plan document contains the following intervention, "Ensure resident is wearing non-slip well-fitting shoes". The "Falls Risk Assessment" completed for resident # 755, indicates the resident is considered to be at a high risk of falls.

On June 5, 2014, the inspector asked the DOC about the resident's slippers and they stated that they were surprised and thought that resident #755 routinely wore appropriate footwear. The DOC indicated that they would follow up on this. The licensee failed to ensure that, the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. Inspectors #575 and #106 interviewed staff member #S-107 regarding Family Council. The staff member indicated that the home does not currently have a family council, nor do they convene semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council. The licensee failed to convene semi-annual meetings to advice residents' families and persons of importance to residents of their right to establish a Family Council. [s. 59. (7) (b)]

WN #11: 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)

Findings/Faits saillants :

1. On May 27, 2014, the home's DOC provided the inspector with a copy of the home's admission package, "Long Term Care Admission Agreement" and the completed, MOHLTC, "LTCH Licensee Confirmation Checklist - Admission Process" document.

On June 3, 2014, the inspector interviewed the DOC to determine if the admission package included the home's policy to promote zero tolerance of abuse and neglect of residents. The DOC confirmed that the admission package did not include the home's policy to promote zero tolerance of abuse and neglect of residents. The licensee failed to ensure that the admission package of information includes, at a minimum, the long-term care home's policy to promote zero tolerance of abuse and neglect of residents. [s. 78. (2) (c)]

2. On June 3, 2014, the inspector interviewed the DOC to determine if the admission package included notification of the home's policy to minimize the restraining of residents and how to receive a copy. The DOC confirmed that the admission package did not include information regarding restraints in the home. The licensee failed to ensure that the admission package of information includes, at a minimum, 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. [s. 78. (2) (g)]

3. On June 3, 2014, the inspector interviewed the DOC to determine if the admission package included a disclosure of any non-arm's length relationships that exist between the licensee and other providers who offer care, services, programs or goods to residents. The DOC confirmed that the admission package did not include information regarding disclosure of any non-arm's length relationships that exist between the licensee and other providers who offer care, services, programs or goods to residents. The licensee failed to ensure that the admission package of information includes, at a minimum, 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. [s. 78. (2) (n)]

4. On June 3, 2014, the inspector interviewed the DOC to determine if the admission package included information about the Residents' Council. The DOC confirmed that the admission package did not include information regarding Residents' Council. The licensee failed to ensure that the admission package of information includes, at a minimum, information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package. [s. 78. (2) (o)]

5. On June 3, 2014, the inspector interviewed the DOC to determine if the admission package included an explanation of whistle-blowing protections related to retaliation. The DOC confirmed that the admission package did not include information regarding an explanation of whistle-blowing protections related to retaliation. The licensee failed to ensure that the admission package of information includes, at a minimum, an explanation of the protections afforded by section 26, in regards to whistle-blowing. [s. 78. (2) (q)]

WN #12: 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)

Findings/Faits saillants :

1. On May 27, 2014, the home's DOC provided the inspector with a copy of the home's admission On May 27, 2014, the home's DOC provided the inspector with a copy of the home's admission package, "Long Term Care Admission Agreement" and completed "LTCH Licensee Confirmation Checklist - Admission Process".

On June 3, 2014, the inspector interviewed the DOC to determine if the home's policy to promote zero tolerance of abuse and neglect of residents was posted in an accessible area. The DOC confirmed that the home's policy to promote zero tolerance of abuse and neglect of residents, is not posted in the home. The licensee failed to ensure that the following is posted in the home, in a conspicuous and easily accessible location, the long-term care home's policy to promote abuse and neglect of residents. [s. 79. (3) (c)]

2. On June 3, 2014, the inspector interviewed the DOC to determine if the home's policy to minimize the restraining of residents was posted in an accessible area in the home, as well as information about how a copy of the policy can be obtained. The DOC confirmed that the home's policy to minimize the restraining of residents, is not posted in the home. The licensee failed to ensure that the following is posted in the home, in a conspicuous and easily accessible location, 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. [s. 79. (3) (g)]

3. On June 3, 2014, the inspector interviewed the DOC to determine if an explanation of evacuation procedures are posted and communicated in the home. The DOC confirmed that an explanation of the evacuation procedures, are not posted in the home. The licensee failed to ensure that the following is posted in the home, in a conspicuous and easily accessible location, an explanation of evacuation procedures in the home. [s. 79. (3) (j)]

4. On June 3, 2014, the inspector interviewed the DOC to determine if an explanation of whistle-blowing protections related to retaliation was posted in an accessible area with in the home. The DOC confirmed that an explanation of whistle-blowing protections related to retaliation, are not posted in the home. The licensee failed to ensure that the following is posted in the home, in a conspicuous and easily accessible location, an explanation of the protections afforded under section 26, in regards to whistle-blowing protections. [s. 79. (3) (p)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. On June 2, 2014, inspector #575 observed the following housekeeping issues in resident's room. At 1130hrs inspector #575 noted the resident's urinal on the floor in front of the resident's chair and a puddle of urine. At 1200hrs the resident was in the dining area and the urinal remained on the floor with the puddle of urine. At 1500hrs, the resident was in bed and the urine remained on the floor half dried up and the urinal was now at the bedside. The resident's floor was sticky.

As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee failed to ensure that procedures are developed and implemented for, cleaning of the home, including, resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces. [s. 87. (2) (a) (i)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
4. Consent. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. Inspector reviewed the current chart for resident #572 and was unable to find consent for the use of the a lap restraint and bed rails. The inspector asked staff member #S-101 to provide the inspector with the consent for use of the restraint and they were unable to find one. The licensee failed to ensure that the restraining of a resident by a physical device may be included in a resident's plan of care only if the restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker or the resident with authority to give that consent. [s. 110. (7) 4.]

2. Inspector #106 reviewed the "Restraint Records" for resident #572 for April, May, and June 1, 2014 and the following was found:
Lap Restraint Record
-April 2014: no documented assessments, reassessment or hourly monitoring other than when the restraint was applied and removed
-May 2014: no documented assessments, reassessment or hourly monitoring other than when the restraint was applied and removed
-June 1, 2014: no documentation completed for this day

Bed Rails Restraint Record:
-April 2014: no documented assessments, reassessment or hourly monitoring other than when the restraint was applied and removed
-May 2014: no documented assessments, reassessment or hourly monitoring other than when the restraint was applied and removed
-June 1, 2014: no documentation not completed for this day

On June 3, 2014, registered staff member # S-100 told the inspector that the RPNs only document when the restraint is applied and removed on the Restraint records and by checking the "Resident Room Checks". On June 4, 2014, the DOC told the inspector that the RPNs are to document hourly restraint checks on the "Restraint Record" as well as document repositioning and release of the restraint. The homes "Policy of Least Restraint", in the section titled, "Required Documentation", indicates, "Hourly monitoring and assessments must be documented on the restraint flow sheet"

The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 6. All assessment, reassessment and monitoring, including the resident's response. [s. 110. (7) 6.]

3. Inspector #106 reviewed the "Restraint Records" for resident #572 for April, May, and June 1, 2014 and the following was found:
Lap Restraint Record
-April 2014: no documented release and repositioning every 2 hours other than when the restraint was initially applied and removed
-May 2014: no documented release and repositioning every 2 hours other than when the restraint was initially applied and removed
-June 1, 2014: no documentation completed for this day

Bed Rails Restraint Record:
-April 2014: no documented repositioning every 2 hours other than when the restraint was initially applied and removed
-May 2014: no documented repositioning every 2 hours other than when the restraint was initially applied and removed
-June 1, 2014: no documentation not completed for this day

On June 3, 2014, registered staff member # S-100 told the inspector that the RPNs only document when the restraint is applied and removed on the Restraint records and by checking the "Resident Room Checks". On June 4, 2014, the DOC told the inspector that the RPNs are to document all repositioning and release of the restraint on the "Restraint Record".

The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: Every release of the device and all repositioning. [s. 110. (7) 7.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. On June 4 and 5, 2014, inspector #106 observed Over The Counter (OTC) medication on resident # 772's bedside table. The medication did not have a pharmacy label to indicate that it had been provided by the home's pharmacy provider. On June 5, 2014, the inspector asked staff member #S-100, who provided the medication to the resident, they reported that they thought that the family brought it in for the resident. The licensee failed to ensure that no drug is acquired, received or stored by or in the home or kept by a resident unless the drug has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. [s. 122. (1)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. On June 4 and 5, 2014, inspector #106 observed Over The Counter (OTC) medication, sitting on resident # 772's bedside table. On June 5, 2014 the HCR for resident #772 was reviewed and no order for the OCT medication was found. A PSW and a RPN were interviewed by inspector #106 and both indicated that staff will apply this medication to the resident at their request. The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. [s. 131. (1)]

2. On June 5, 2014, inspector #106 asked registered staff member #S-100, who administers the OCT medication to resident #772. Staff member #S-100 indicated that the resident, the resident's family or staff will administer the OCT medication to resident #772. The HCR for resident #772 was reviewed by inspector #575 and no documentation was found that indicated the resident's physician or any other health care provider that is able to prescribe medication approved resident #772 to administer the OCT medication to his or herself. The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident [s. 131. (5)]

3. On June 4 and 5, 2014, inspector #106 observed OCT medication, sitting on resident # 772's bedside table. The HCR for resident #772 was reviewed by inspector #575 and no documentation was found that indicated the resident's physician or any other health care provider that is able to prescribe medication approved resident #772 to keep the medication at their bedside. The licensee failed to ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5), keeps the drug on his or her person or in his or her room except, as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident. [s. 131. (7)]

WN #17: 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. On May 27, 2014, the home's DOC provided the inspector with a copy of the home's admission package, "Long Term Care Admission Agreement" and completed "LTCH Licensee Confirmation Checklist - Admission Process". On June 3, 2014, the inspector interviewed the DOC to determine if the admission package included information on the ability to retain a physician or RN (EC) to perform required services. The DOC confirmed that the admission package did not include information regarding the ability for residents to retain a physician or RN (EC) to perform the required services. The licensee failed to ensure that the admission package of information includes, at a minimum, the resident's ability to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1). [s. 224. (1) 1.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following:

s. 241. (1) Every licensee of a long-term care home shall establish and maintain at least one non-interest bearing trust account at a financial institution in which the licensee shall deposit all money entrusted to the licensee's care on behalf of a resident. O. Reg. 79/10, s. 241 (1).

Findings/Faits saillants :

1. During a stage 1 family interview a family member reported to the inspector that they do not receive a monthly statement for the money that the home in trust has to ensure that day to day incidentals are paid for. On June 3, 2014, the inspector asked the DOC if residents and families are provided with a monthly statement of the money held in trust.

The DOC reported that the home does not have trust accounts for the resident, instead they keep a petty cash safe to store resident money in. These funds are audited monthly to ensure all money is accounted for, but residents do not receive a monthly statement. The licensee failed to establish and maintain at least one non-interest bearing trust account at a financial institution in which the licensee shall deposit all money entrusted to the licensee's care on behalf of a resident. [s. 241. (1)]

Issued on this 9th day of September, 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) :	MARGOT BURNS-PROUTY (106), LINDSAY DYRDA (575)
Inspection No. / No de l'inspection :	2014_211106_0010
Log No. / Registre no:	S-000210-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 20, 2014
Licensee / Titulaire de permis :	SIOUX LOOKOUT MENO-YA-WIN HEALTH CENTRE Fifth Avenue South, PO Box 909, SIOUX LOOKOUT, ON, P8T-1B4
LTC Home / Foyer de SLD :	WILLIAM A. "BILL" GEORGE EXTENDED CARE FACILITY 75 FIFTH AVENUE, SIOUX LOOKOUT, ON, P8T-1K9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Anderson

To SIOUX LOOKOUT MENO-YA-WIN HEALTH CENTRE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

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

Order / Ordre :

The licensee shall ensure that the organized programs required under section 48 of the Regulation, specifically the Continence Care and Bowel Management Program and under section 11 of the Act, the Nutrition Care, Dietary Services and Hydration Program, that there is a written description of the program that includes its goals and objectives, relevant policies, procedures, and protocols, methods to reduce risk, outcomes monitoring, and protocols for referral of residents to specialized resources where required.

Grounds / Motifs :

1. Inspector #575 determined that resident #765's plan of care, in regards to nutritional requirements, does not provide clear directions to staff. On June 4, 2014, inspector #575 interviewed the DOC regarding the Nutrition Care, Dietary Services and Hydration Program in the home. The DOC indicated that the home does not have a formal Nutrition and Hydration Program.

The licensee failed to ensure that for the organized program required under section 11 of the Act, that there is a written description of the Nutrition Care, Dietary Services and Hydration Program that includes its goals and objectives, relevant policies, procedures, protocols, provides methods to reduce risk, methods to monitor outcomes, and protocols for referral of resident to specialized resources where required. (575)

2. On June 3, 2014, inspector #575 reviewed the current care plan document for resident #772. The care plan document indicates staff are to monitor and record urine output daily.

On June 3, 2014, inspector #575 reviewed the urinary output sheets and progress notes for resident #772 and noted that the output was not recorded daily. On June 3, 2014 inspector #575 interviewed staff member #S-100 regarding resident #772. The staff member stated that the urinary output is not always recorded.

On June 3, 2014, inspector #575 interviewed the DOC regarding the Continence Care and Bowel Management Program. The DOC stated that the home does not currently have a formal Continence Care and Bowel Management Program. The licensee failed to ensure that the organized program required under section 48 of the Regulation, specifically the Continence Care and Bowel Management Program, that there is a written description of the program that includes its goals and objectives, relevant policies, procedures, and protocols, methods to reduce risk, outcomes monitoring, and protocols for referral of residents to specialized resources where required. (575)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2014

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, specifically in regards to residents # 768, #771, and #752.

Grounds / Motifs :

1. The "Side Rails Release Form", signed by resident #768's power of Attorney (POA) was reviewed by inspector #106. The form indicated that side rails are to remain down for resident #768. The plan of care for resident #768 was reviewed and it indicated, bed rails used for bed mobility or transfer for resident #768. On May 28, 2014, the inspector observed the bed rails of resident's #768's bed in the up position and on June 4, 2014, bed rails were again observed in the up position. The HCR for resident #768 was reviewed and no evidenced based assessment of the resident's bed rails or bed system was found. (106)

2. On May 29, 2014 inspector #575 reviewed the most recent care plan for resident #771 dated November 4, 2013. The care plan indicates that bed rails are used for bed mobility or transfer and that the resident requires bed rails up when in bed and call bell in reach at all times as resident may attempt to transfer self on own. The Health Care Record (HCR) for resident #771 was reviewed and no evidenced based assessment of the resident's bed rails or bed system was found. (575)

3. Resident #752's plan of care was reviewed by the inspector and it indicates the use of bed rails when the resident is in bed. Staff member #S-101 reported to the inspector that the resident will become agitated if staff do not apply the bed rails when they are in bed. The HCR for resident #752 was reviewed and no evidenced based assessment of the resident's bed rails or bed system was found.

On May 29, 2014, inspector #575 interviewed the DOC regarding bed rail assessments. The DOC stated that the home does not complete a specific bed rail assessment using evidence-based practice and that the use of bed rails are determined by staff through their own clinical judgment. The licensee failed to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident. (106)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 10, 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 20th day of August, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MARGOT BURNS-PROUTY

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