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
May 7, 2013	2013_159178_0006	T-146-13	Resident Quality Inspection

Licensee/Titulaire de permis

ADVENT HEALTH CARE CORPORATION
541 Finch Avenue West, NORTH YORK, ON, M2R-3Y3

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

VALLEYVIEW RESIDENCE
541 Finch Avenue West, NORTH YORK, ON, M2R-3Y3

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

SUSAN LUI (178), DIANE BROWN (110), SARAN DANIEL-DODD (116)

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): April 9, 10, 11, 12, 15, 16, 17, 18, 22, 23, 24, 25, 26, 29, May 6, 2013

The following Complaint/Critical Incident Inspection was inspected concurrently during this Resident Quality Inspection and the findings are included in this report:
T-1551-12/T-1611-12

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Senior Nurse Manager, Nurse Manager, RAI-MDS Coordinator, Environmental Services Manager, Food Services Manager, Recreation Services Manager, Office Coordinator, Registered Dietitian, Recreation Assistants, Registered Staff, Personal Support Workers (PSWs), Physiotherapist, Physiotherapy Assistants, Quality Improvement Coordinator, Resident and Family Relations Coordinator, Housekeeping Staff, Laundry Staff, Maintenance Staff, Dietary Staff, residents, and families of residents.

During the course of the inspection, the inspector(s) observed meal service, observed resident care, observed home environment, measured air temperatures, reviewed resident and home records, reviewed home policies and procedures, reviewed employee records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee failed to ensure staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Staff interviews and record review confirm that staff in the nursing and dietary departments failed to collaborate with each other in their assessments of residents' nutrition needs so that their assessments are integrated, consistent with and complement each other.

Staff interviews and record review revealed the following lack of collaboration amongst staff related to the nutritional assessment of resident # 797, who had been identified to have poor appetite and low body weight:

- Nursing staff failed to initiate and complete a re-weigh as per home protocol when the resident experienced a significant weight change (18% within one month). Furthermore, even after the Registered Dietitian (RD) specifically requested a re-weigh to confirm accuracy of the weight, the re-weigh was not completed. As a result, the resident's significant weight change was not assessed by the RD.

-Nursing staff failed to notify and collaborate with the RD related to resident 797's ongoing refusal of bedtime supplements.

-The Food Services Manager failed to collaborate with the RD in the assessment of resident #797's dietary needs.
The RD has been assessing resident #797's nutritional status based on the belief that the resident was receiving a modified diet as per the resident's diet order and plan of care. In practice, the resident has been receiving regular menu choices for the past several months, since initiated by the Food Services Manager after her discussion with the resident's power of attorney (POA). [s. 6. (4) (a)]

2. Staff interviews and record review revealed the following lack of collaboration between nursing and dietary staff related to the nutritional assessment of resident # 854, who had been identified to have poor appetite, unplanned weight loss and skin breakdown:

Resident # 854 experienced decreased intake and skin breakdown. Nursing staff notified the resident's Physician who ordered nutritional supplements, however the RD

was not made aware of resident's change in nutritional status and therefore did not complete a nutritional assessment. [s. 6. (4) (a)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to Resident #892 as specified in the plan.
Resident #892, who has a history of heart failure treated with diuretics, was to be weighed daily as ordered by physician on December 28, 2012.
Staff interviews and record review reveal that the resident was not weighed on December 28, 29, 30, 31, 2012, January 1, 2, 2013. [s. 6. (7)]

4. The licensee failed to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and have convenient and immediate access to it.

Resident #883 who is identified at high risk for falls on the plan of care, experienced a fall on April 7, 2013. Staff interviews on April 17 and 18, 2013 reveal that Registered staff and PSWs assigned to the resident were not aware of the resident's high risk for falls. PSWs assigned to the resident were not aware that the resident had fallen on April 7, 2013. [s. 6. (8)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff and others involved in the nutrition care of residents collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #2: 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:

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. 2007, c. 8, ss. 24 (1), 195 (2).
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. 2007, c. 8, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).
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. A person 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 risk of harm to the resident has occurred or may occur, failed to immediately report the suspicion and the information upon which it was based to the Director under the Long Term Care Homes Act (LTCHA) [s.24(1)2].
Resident and staff interview revealed that resident #892 reported to two staff members that his/her call bell had been removed out of reach by a staff member from another shift. This information was not communicated to the home's administration or to the Director under the LTCHA. [s. 24. (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 any staff member who has 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 risk of harm to the resident has occurred or may occur, shall immediately report the suspicion and the information upon which it was based to the Director under the Long Term Care Homes Act (LTCHA), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #883 identified at high risk for falls, experienced an unwitnessed fall on April 7, 2013. Staff interviews and record review confirmed that a post fall assessment using a clinically appropriate instrument that is specifically designed for falls was not conducted for this resident or for other residents who have fallen. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds are assessed by a registered dietitian (RD) who is a member of the staff of the home.

Record review and staff interviews confirm the following:
-Resident #854 experienced skin breakdown on two separate occasions, and was not assessed by the RD on either occasion.
-Resident #797 experienced skin breakdown in the form of a pressure ulcer, and was not assessed by the RD. [s. 50. (2) (b) (iii)]

2. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the Registered nursing staff, if clinically indicated.

Resident #890 has a stage four pressure ulcer on the coccyx that requires dressing changes to be conducted three times per week and whenever required.
Staff interviews and record review confirm that Resident #890's wound was not reassessed weekly. Reassessments of the resident's wound have been conducted on a monthly and quarterly basis, as opposed to weekly. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds: -are assessed by a registered dietitian (RD) who is a member of the staff of the home, and -are reassessed at least weekly by a member of the Registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes

Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with a change of 5 per cent of body weight, or more over one month are assessed using an interdisciplinary approach, and that actions are taken and that outcomes are evaluated.
Staff interviews and record review confirm the following:
-Resident #797 who is at nutritional risk related to poor appetite and low body weight, experienced an unplanned 5% weight loss that was not assessed using an interdisciplinary approach, and actions were not taken. The resident's weight loss was not identified or assessed, and actions were not taken.
- Resident #854 experienced a greater than 5% weight loss in one month which was not identified or assessed by nursing staff or the RD. As a result, no actions were taken to address the resident's weight loss. [s. 69.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with a change of 5 per cent of body weight, or more, over one month are assessed using an interdisciplinary approach, and that actions are taken and that outcomes are evaluated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's substitute decision-maker (SDM) and any other person specified by the resident were immediately notified upon becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being.
On April 10, 2013 the inspector informed management staff of Resident #892's allegation that an identified staff member had removed the call bell from within his/her reach on multiple occasions. On April 22, 2013 the inspector informed management staff of Resident #892's allegation that the same identified staff member had handled him/her roughly during care. Staff interviews confirm that the family of the resident was not informed of either allegation until April 24, 2013. [s. 97. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident's substitute decision-maker (SDM) and any other person specified by the resident were immediately notified upon becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being, to be implemented voluntarily.

WN #7: 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:

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 O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act.
Staff interviews and record review confirm that the home's skin and wound care program policy #NMIIS010 does not address the LTCHA's requirement for residents exhibiting altered skin integrity to be reassessed at least weekly by a member of the registered nursing staff [s.50 (2)(b)(iv)]. [s. 8. (1)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home furnishings and equipment are kept clean and sanitary.
Observations revealed that the grout in the shower floors in shower rooms on 3 east, 4 east and 4 west units were stained dark and appeared unclean. Also, the caulking between the shower floor and bathroom floor in these rooms contained built up grime. Staff interviews revealed that these shower rooms are to be cleaned once monthly. However, the home was unable to determine when these areas were last cleaned. [s. 15. (2) (a)]

2. The licensee has failed to maintain the home, furnishings, and equipment are maintained in a safe condition and in a good state of repair.
The following observations were made repeatedly throughout the inspection period:
- Drywall in the 3 east shower room was scraped and chipped, exposing bare wood at the base of one wall.
-An 8 inch by 5 inch hole was noted in the drywall above the baseboard of one wall of the 4 west shower room.
Staff interviews and record review confirm that these areas of disrepair had not been reported to the maintenance department and that a request for repair was not entered in the maintenance log book as per the home's protocol. [s. 15. (2) (c)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
16. Activity patterns and pursuits. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care for Resident #812 was based on an interdisciplinary assessment of the resident's activity patterns and pursuits.

Resident #812 informed the inspector that his/her scheduled shower times consistently conflict with the evening activity programs the resident wishes to attend. The resident has informed both nursing and recreation staff of this conflict, with no resolution. Staff interview confirmed that the current shower schedule does impede on the resident's activity patterns and pursuits, however the resident's plan of care has not been adjusted to allow the resident to pursue his/her activity patterns as desired. [s. 26. (3) 16.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids labeled within 48 hours of admission and of acquiring, in the case of new items.
Inspectors observed over the course of two weeks, an unlabeled previously used razor and an unlabeled previously used hair brush stored in the shower room on 2 west. Staff interviewed could not identify the owners of these items. [s. 37. (1) (a)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations. Record review and staff interviews confirm that management does not respond to Residents' Council concerns in writing, and has not done so since June 2012. [s. 57. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the home has a dining and snack service that includes a review of meal and snack times by the Residents' Council.
Record review and resident and staff interviews confirm that the Residents' Council has not reviewed meal and snack times. [s. 73. (1) 2.]

2. The licensee has failed to ensure that all residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance.
On April 9, 2013 at lunch, the inspector observed that resident #929 was served soup 10 minutes before assistance was provided for the resident to eat.
Staff confirmed that the resident requires total assistance to eat his/her meals. [s. 73. (2) (b)]

WN #13: 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. Staff interview and review of the admission package confirm that the licensee failed to ensure that the admission package includes an explanation of the duty under section 24 to make mandatory reports (related to incidents resulting in harm or risk of harm to a resident). [s. 78. (2) (d)]

2. Staff interview and review of the admission package confirm that the licensee failed to ensure that the admission package includes the home's procedure for initiating complaints to the licensee. The home's procedure for the handling of complaints is included in the admission package, however the process for initiating a complaint is not included. [s. 78. (2) (e)]

3. Staff interview and review of the admission package confirm that the licensee failed to ensure that the admission package includes the telephone number of the licensee. [s. 78. (2) (h)]

WN #14: 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. Observations and staff interview confirm that the licensee failed to ensure that the name and telephone number of the licensee is posted in the home in a conspicuous and easily accessible location in a manner that complies with the requirements. [s. 79. (3) (h)]

2. Observations and staff interview confirm that the licensee failed to ensure that an explanation of evacuation procedures is posted in the home in a conspicuous and easily accessible location in a manner that complies with the requirements. [s. 79. (3) (j)]

WN #15: 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. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home sought the advice of the Residents' Council in developing and carrying out the survey, and in acting on its results. Interviews with staff and the resident council president indicate that the home did not seek the advice of Residents' Council in developing and carrying out the satisfaction survey. [s. 85. (3)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies.
On Apr 17, 2013 the inspector observed non drug-related items in the 4 east medication cart. The medication cart contained a pair of sunglasses and an engraving tool. The inspector also observed two envelopes labelled with the names of staff members in the narcotic box of the medication cart. [s. 129. (1) (a)]

2. On April 17, 2013, the inspector observed non drug-related items in the 3 west medication cart. The medication cart contained bottom dentures belonging to an identified resident.
Staff interview confirmed that the denture plate has been stored in the medication cart since February 2013. [s. 129. (1) (a)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Observations and staff interview confirm that the licensee has failed to post in the home and communicate to residents the most recent audited reconciliation report as provided for in clause 243(1)(a). [s. 225. (1) 3.]

WN #18: 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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to 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.

Staff interview confirmed that no documentation is available to confirm the following residents were screened for tuberculosis:

Resident #834
Resident #858
Resident #850
Resident #854
[s. 229. (10) 1.]

2. The licensee failed to ensure that residents are offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Record review and staff interview confirm that Resident #818 and Resident #858 were not offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
The Director of Care confirmed that the home is currently not following the immunization schedule posted on the Ministry website because the home's physicians are not in support of this practice. [s. 229. (10) 3.]

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

Issued on this 14th day of May, 2013

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

Susan Sin (178)