Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 14, 15, 16, 17, 18, 22, 23, 24, 25, 26, 28, 29, 30, 31, Jun 1, 4, 5, 6, 7, 8, 11, 12, 13, 14, 19, 20, 21, 28, 2012	2012_087128_0010	Resident Quality Inspection

Licensee/Titulaire de permis

RITZ LUTHERAN VILLA
R.R. 5, MITCHELL, ON, N0K-1N0

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

RITZ LUTHERAN VILLA
PART LOT 16, CON 2, LOGAN TWN, R.R. #5, MITCHELL, ON, N0K-1N0

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

RUTH HILDEBRAND (128), BONNIE MACDONALD (135), MARIAN MACDONALD (137)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with with the Chief Executive Officer, Acting Chief Executive Officer, Director of Care, Acting Assistant Director of Care, Nutrition Services Director, Building Services Director, Human Resources Director, Campus Life Enrichment Director, 4 Physicians, Consultant Pharmacist, Registered Dietitian, Physiotherapist, Resident Assessment Instrument Coordinator, Administrative Assistant, 2 Receptionists, Nursing Administrative Assistant/Staffing Clerk, 5 Registered Nurses, 5 Registered Practical Nurses, 20 Personal Support Workers, Programs Support Coordinator, Programs Support Assistant, Restorative Care Coordinator, 2 Physiotherapy Assistants, 4 Dietary Aides, 3 Housekeeping Aides, 2 Maintenance Workers, Family Council President, 5 Family Members and 47 Residents.

During the course of the inspection, the inspector(s) conducted a tour of all resident areas and common areas, observed residents and the care provided to them and observed meal service. Medication administration and storage were observed and the clinical records for identified residents were reviewed. The inspectors reviewed admission and resident charges records, policies and procedures, as well as minutes of meetings pertaining to the inspection.
Log #L-000691-12.

This inspection was done in conjunction with a Critical Incident inspection, completed by Inspector #203, Carmen Priester, who joined the RQI team for orientation. Refer to Inspection # 2012_092203_0012, Log # L-000694-12.
This inspection was also done concurrently with an Other Inspection conducted by Karin Mussart, Inspector #145. Refer to Inspection #2012-093145-0021, Log #000769-12.

The following Inspection Protocols were used during this inspection:

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Training and Orientation

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

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

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. An identified resident fell sustaining an injury, while walking without being supervised.
A record review for the resident revealed that a post falls assessment had been completed the week before after a previous fall. The post falls assessment indicated the factor contributing to the fall was the resident's unsteady gait and the action plan was to monitor resident and supervise with walking.
The plan of care, however, does not have interventions documented to ensure staff are aware that the resident is to be monitored and supervised while walking.
The Director of Care confirmed the resident's plan of care does not provide clear directions to recreation staff and others who provide direct care to the resident, related to it not indicating that the resident is to be monitored and supervised with walking.
[LTCHA, 2007 S.O. 2007, c.8, s.6.(1)(c)]
2. A clinical record review was completed for an identified resident who has had several falls, to determine if the care plan provides clear directions for care staff and others who provide direct care to the resident.
The resident fell and was re-assessed by Restorative Care and the assessment indicated the following:
Due to the resident's inability to transfer safely with 2 people while using the standard walker, it is suggested that the resident be a "2 person transfer and no walker to stand and pivot into a chair. The resident appears to have no concept of what to do with the walker at this time."
In review of the resident's plan of care, the interventions for transfer of the resident stated the following:
Continue to transfer the resident with 2 persons and walker. Instruct the resident on proper walker usage.
Staff interviews with personal support workers confirmed that staff were transferring the resident from the bed to chair using a walker.
The Restorative Care Coordinator confirmed that the resident's plan of care did not provide clear directions to staff and others who provide direct care to the resident when it stated that resident could transfer using a walker.
[LTCHA, 2007 S.O. 2007, c. 8, s. 6 (1) (c)]
3. A clinical record review for an identified resident revealed that there is no evidence to support that the resident was assessed and the plan of care reviewed and revised post hospitalization.
A staff interview with the RAI Coordinator confirmed that this resident's plan of care was not reviewed and revised when the resident's care needs changed.
[LTCHA, 2007, S.O. 2007, c.8,s.6(10)(b)]
4. A review of the plan of care for an identified resident revealed that there are no documented oral assistance interventions noted on the plan of care to provide direction to staff in caring for this resident.
A registered practical nurse confirmed that the plan of care does not provide clear direction to staff as it does not contain any interventions related to oral care.
[LTCHA, 2007, S.O. 2007, c.8, s.6(1)(c)]
5. The plan of care for an identified resident noted the resident is to receive 1:1 exercises 1-3x /week. However, a review of the Resident's Physiotherapy Resident Logs for 2012, revealed these exercises have not been recorded as occurring since December, 2011.
The Physiotherapist revealed that the resident no longer requires this exercise. He confirmed the plan of care should have been revised as the care set out in the plan was no longer necessary.
[LTCHA, 2007 S.O. 2007, c.8, s.6.(10) (b)]
6. A review of the clinical record for an identified resident revealed that the resident has been experiencing a wound(s) for the past four months. Clear direction has not been provided to staff as goals and interventions related to wounds are not identified on the plan of care.
The Director of Care and a registered practical nurse confirmed that goals and interventions related to wounds were not identified on the plan of care. The ADOC shared that the registered staff were expected to include goals and interventions related to wounds in the plan of care.
[LTCHA, 2007, S.O. 2007, c.8, s.6(1)(c)]
7. A clinical record review for an identified resident revealed that the plan of care related to activation did not provide staff with clear direction to identify what the resident was interested in when it stated "offer activity program directed toward specific interests/needs of resident". The resident's interests were not documented.
A review of the program records for this resident revealed that there has been no attendance at any activities in the month of May and only two "one on one" activities were offered.
Programs staff acknowledged that the resident won't come to the activities that they offer. The plan of care has not been revised even though the interventions related to activity patterns and pursuits have not been effective. There was no documentation to support that different approaches have been considered despite the fact that the resident does not

attend activities.
The Campus Life Enrichment Director agreed that the care plan interventions were not individualized for this resident and the home needed to provide clear direction to staff. She also acknowledged that the interventions that the home was using were not working and this resident should have been reassessed.
[LTCHA, 2007, S.O. 2007, c.8, s.6(1)(c) and s.6(11)(b)]
8. A review of an identified resident's clinical record revealed that the only documented restraint assessment was completed, indicating a a specific type of restraint to be used, related to falls. This assessment was not a collaborative assessment involving all aspects of care. There is still no physician order for this restraint and there is no documented evidence of restraint monitoring by any nursing staff.
The Director of Care confirmed that there has not been a collaborative assessment of this resident and that staff should have obtained a physician's order and should be monitoring the resident's restraint.
[LTCHA, 2007, S.O. 2007, c.8, s. 6 (4) (a)]
9. A review of the plan of care for an identified resident revealed that a safety device is to be turned on. The care specified in the plan of care was not followed as the safety device was observed off on May 23, 2012 and twice on May 24, 2012.
A personal support worker acknowledged that he/she is aware that the safety device is to be turned on but he/she knows that staff don't always turn it on as he/she often finds it turned off.
The DOC acknowledged, May 24, 2012, that her expectation is that the plan of care is to be followed and that the safety device is turned on.
May 25, 2012 the safety device was observed turned off, again, despite the home being notified the day before.
[LTCHA, 2007, S.O. 2007, c.8, s. 6 (7)]
10. An identified resident was observed in the hallway ambulating at 14:28. The resident has a safety device in place but staff took 6 minutes to respond.
A personal support worker acknowledged that the resident was at risk of falling and that nobody was on the floor while report was being given. He/she indicated that report is supposed to start 5 minutes before end of shift so that staff would be available until 14:30 to cover the floor.
He/she acknowledged that this was a safety risk for this resident as the staff were aware that this resident is to be monitored any time the safety device goes off.
A registered practical nurse acknowledged that the expectation is that staff are to respond immediately when these safety devices sound. He/she also indicated that he/she really wasn't sure who was to be monitoring the floor while report was happening.
[LTCHA, 2007, S.O. 2007, c.8, s. 6 (7)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following subsections:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. All inspection team members observed an identified resident, numerous times per day, each day throughout the inspection. Staff walking by the resident failed to respond to his/her requests. The pattern of inaction resulted in the resident not being provided adequate food and fluids. The resident is at high nutritional risk.
On May 17, 2012 the resident stated that he/she was hungry and a PSW advised the resident that he/she would have to wait until lunch for something to eat. No action was taken to provide the resident with something to eat until MOHLTC intervention was provided.
On May 17, 2012, the identified resident told Inspectors #128 and #137 that he/she wanted to go to bed. Four personal support workers were in the nursing station when Inspector #128 informed them that the resident wanted to go to bed. The PSW's laughed and said that there is no way that he/she will go lay down. They took no action to speak with the resident to see if he/she actually wanted to go to bed.
It was noted that the resident was not observed in any activities, throughout the inspection.
On May 24, 2012, the identified resident was observed refusing to go to the dining room for breakfast. Staff did offer him/her breakfast but a tray was not provided. The resident was offered juice from the morning snack cart but he/she refused it. He/she was not offered any other beverages or any food. At 10:58, the resident was provided with a preferred beverage after he/she told the DOC that he/she was thirsty.
A staff interview was conducted May 24, 2012 @ 11:00 with the Director of Care to determine expectations related to offering food to residents who don't eat their breakfast. She stated that the expectation is that residents are offered food at morning snack if they don't eat their breakfast. Inspector #128 informed the DOC that this resident did not have any breakfast and that he/she was not offered anything to eat at morning snack. The DOC expressed sadness at hearing this and provided the resident with more of the preferred beverage and a snack.
Inspector #128 identified to the DOC that interventions that the home had in place were not working and that the home needed to reassess the resident.
On May 24, 2012 @ 14:20, a staff interview was held with the Acting CEO to advise her of ongoing significant risks being identified in the home, including that the above resident was being neglected. Inspector #128 informed the Acting CEO that this resident was not treated the same as other residents related to lack of activation, meals and fluids not being offered and staff not listening to the resident.
The Acting CEO expressed concern about what the inspector was telling her and was concerned that if the staff were ignoring this resident then they could be ignoring other residents, too. She agreed that the home needed to look at this resident with a new set of eyes.
Later the same day, the Director of Nutrition Services identified that she was aware that the home had not been monitoring this resident's food and fluid records like they should be when the resident hasn't been eating and drinking. She indicated that she was aware that the resident was below the fluid alert levels on certain days and that the home had not been meeting the resident's needs.
The DOC and the Director of Nutrition Services confirmed that the expectation was that all residents who did not come to the dining room were provided with a tray at meal time, including cognitively impaired residents who refuse a meal.
[LTCHA, 2007, c. 8, s. 19 (1)]

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. A review of the Abuse or Suspected Abuse of a Resident policy #102-06, dated October 2011, revealed that the policy does not reflect mandatory reporting to the MOHLTC. The time frames for investigation are also not in compliance with the LTCHA and Regulations.
The Acting CEO confirmed that the policy does not reflect expectations in the LTCHA and Regulations.
[LTCHA, 2007, S.O. 2007, c.8,s. 20(2)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records
Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The Monitoring Resident's Weight and Height, Nutrition Care policy #704-11b, dated December 2009, states: if a new weight represents a significant change of 5% or more in one month, 7.5% or more in 3 months and 10% or more in 6 months; nursing re-weighs residents to confirm the weight. This policy was not complied with when high risk residents were not reweighed as of May 28, 2012 and had the following percentage weight losses in one month, since April 2012:
Resident #1 - 9.0%
Resident #2-7.8%
Resident #3-9.4%
Resident #4- 9.1 %
Resident #5 7.3%
The registered dietitian confirmed she often has to request that residents be re-weighed before assessing residents for weight loss.
The Director of Care confirmed, her expectation is that residents are reweighed when there is a significant weight change of 5% or more in one month.
[O.Reg. 79/10, s.8(1)(b)] (135)
2. A review of the Tray Service policy #703-06, dated May 2007, revealed that residents who are not in the dining room are to be provided a tray.
This policy has not been complied with for an identified resident who was observed without a tray and not in the dining room at meal time.
The Director of Nutrition Services confirmed that her expectation is that the home's policy is followed and that all residents are to be provided a tray at meals when they are not in the dining room.
[O.Reg. 79/10, s.8(1)(b)]
3. A review of clinical records for an identified resident revealed that the resident has had six falls since August 2011.
The Falls Prevention and Management policy #202-69, dated July 2008 was not complied with when the resident fell and the following information was not completed as part of the post falls assessment:
-Notify the attending Physician and ensure immediate treatment after the fall;
-Notify the resident's family resident has fallen;
-Complete fall incident report in detailed progress notes;
-Investigate the contributing factors associated with the fall and modify care plan as indicated.
A post falls assessment tool noted "no side rails" as the contributing factor for the resident's fall, while the plan of care does not reflect that resident requires side rails while in bed.
The Director of Care confirmed her expectation is that Falls Prevention and Management policy #202-69 July 2008, is complied with when doing a post falls assessment.
[O.Reg. 79/10s.8(1)(b)]
4. There is no documented evidence that there is a plan, policy, protocol, procedure, strategy or system in place that is in compliance and implemented in accordance with all applicable requirements under the Act to address residents being offered an annual dental assessment.
Three of three residents reviewed related to dental assessments were not provided an annual dental assessment.
The Director of Care confirmed this and acknowledged that she was not aware that this was a requirement.
[O. Reg. 79/10, s.8(1)(a)] (135)
5. The home has failed to ensure that the policy on Skin Care and Preventing, #202-87, dated March 2008, was complied with. This was evidenced by a clinical record review for an identified resident that revealed a skin assessment was not completed for this resident post two hospitalizations.
The RAI coordinator confirmed that the policy was not followed when registered staff did not conduct a head to toe assessment upon the resident's return from hospital.
[O. Reg. 79/10, s.8(1)(b)]
6. The Nutrition Assessment and Risk Identification, Nutrition Care #704-04 policy, dated November 2008, states: resident who has experienced a change of health that affects nutrition status i.e. re-admission from hospital is referred to the RD using the Nutritional Referral form Appendix B.
This policy was not complied with when an identified resident returned from hospital and was not referred to the Dietitian.
The Dietitian confirmed that the resident had not been referred for a nutritional assessment after returning from the hospital.
[O.Reg. 79/10, s.8(1)(b)]
7. The Monitoring Resident's Weight and Height, Nutrition Care policy, #704-11b, dated December 2009, states: each resident's height is taken at the following times: on admission and annually thereafter.

In record reviews, the Height monitoring policy was not complied with when 15 of 15 (100%) residents reviewed did not have their heights taken annually.
[O.Reg. 79/10, s.8(1)(b)]
8. The AM. Care/HS. Care policy #203-61, dated April 1999, revealed that residents are to receive denture care AM. and HS.
The policy was not complied with when 3 of 3 residents were not provided denture care in the morning and evening, May 1-27, 2012.
The Director of Care confirmed the policy was not complied with when the three residents were not provided dental/oral care twice daily. [O.Reg.79/10, s. 8 (1)(b)](137)

The Director of Care also confirmed that policy # 203-61, AM.Care/HS. Care, dated April 1999 was not updated to reflect current legislative requirements to include residents with their own teeth, needing to receive twice daily mouth care.
[O.Reg.79/10, s. 8 (1)(a)]
9. A review of the Medical Pharmacies Readmission of Residents from Hospital Policy # 7-4 revealed that all readmission orders are to be written on the "Physician's Order" sheet or "One Write Admission Form".
A clinical record review revealed that an identified resident returned from hospital in the evening and the accompanying hospital Physician Orders were not transcribed onto the home's physician order sheet or onto the "One Write Admission Form". The orders were not processed until the next afternoon and signed by only one registered staff member. There is no documented evidence that the orders were checked and co-signed by a second registered staff member.
The Director of Care confirmed that a member of the registered nursing staff didn't check and co-sign the orders and that policy was not complied with.
[O. Reg. 79/10, s.8(1)b]
10. A review of the Administration of Medications/Nursing Department Policy # 201-56, dated December 1998/revised April 1, 1999 revealed that all residents transferred to an acute care hospital will have new orders written upon return.
This policy was not complied with as evidenced by: a review of the Best Possible Medication History - Physician's orders for an identified resident revealed documentation to "Continue all previous orders". There is no documented evidence that new orders were written upon return.
The Director of Care confirmed that new orders had not been written and that the policy was not complied with.
[O. Reg. 79/10, s.8(1)(b)]
11. There is no documented evidence to support that there are policies related to the Infection Prevention and Control program, including but not limited to the infection prevention and control team, program evaluation and daily monitoring of infections.
The DOC and ADOC confirmed that policies are not in compliance with the LTCHA and regulations related to the Infection Prevention and Control program.
[O. Reg. 79/10, s.8(1)(a)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following subsections:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. On May 14, 23 and 24, 2012, it was observed that the resident-staff communication "call bell" system was not easily accessible in the rooms of three residents.
The Director of Care confirmed that the expectation is that resident's "call bells" must be easily accessible to residents in their rooms, at all times.
[O.Reg.79/10,s.17.(1)(a)]
2. During the initial tour of the home on May 14, 2012, it was observed that the west wing lounges and north wing lounges, on both floors, are not equipped with a resident-staff communication and response system that is available and accessible to residents.
The Building Services Director acknowledged awareness that the home needed to have call bells in all areas accessible to residents and that they needed to be installed in the West lounge on first and second floors, as well as the North lounge on second floor and the physio treatment area, North first floor.
[O.Reg.79/10,s.17.(1)(e)] (128)

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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-staff communication system/call bells can be easily accessed and used by residents at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

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

Findings/Faits saillants :

1. A record review completed on May 23, 2012, for an identified resident, revealed that the resident was admitted more than a year ago. At the time of the inspection, there was no plan of care for this resident related to recreation and social activity patterns or pursuits.
The Campus Life Enrichment Director confirmed the resident has not had a recreation and social activity plan of care developed, since admission, to direct staff providing resident care.
[O.Reg.79/10,s.26 (3)16.]
2. An identified resident's average daily fluid intake in a 5 day period was reviewed from the Point of Care fluid intake records. They revealed an average intake of 597 mls./day or 45.8 % of resident's daily fluid requirement of 1305 mls./day as noted in the plan of care. The resident's poor fluid intake was also identified by the Dietitian in a MDS assessment.
The Registered Dietitian confirmed that the resident was not referred for assessment when there was a significant change in hydration status; i.e. resident's fluid intake for a 5 day period was less than 750 mls./day for 3 consecutive days. Resident was not referred to the Dietitian as per the Food and Fluid Intake and Monitoring policy-Nursing #202-66, May 2012.
The Director of Care confirmed her expectation is that residents are referred to the Dietitian after 3 consecutive days of low fluid intake of less than 750 mls/day.
[O. Reg.79/10 s. 26 (4)(a)]
3. An identified resident returned to the home from a hospital admission. The resident's nutritional status was not assessed by the Dietitian upon return from the hospital, even though there was a significant change in health status.
The Dietitian confirmed that the resident's nutritional status and/or any risks related to nutrition were not assessed.
[O. Reg. 79/10, s. 26 (4)(a)]
4. A review of an identified resident's clinical record revealed that there was not an interdisciplinary assessment as the only discipline involved in the assessment with respect to safety risks was nursing.
The physiotherapist confirmed that physiotherapy services are not consulted/contacted related to interdisciplinary assessment of safety risks.
[O. Reg. 79/10, s.26(3)19]

Additional Required Actions:

CO # - 006, 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

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

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

Findings/Faits saillants :

1. A review of the Campus Life Enrichment policy and procedure manual revealed that it has not been updated to reflect the LTCHA and Regulations. There are no goals and objectives nor policies related to monitoring outcomes and ensuring that residents are reassessed with resident's responses to interventions documented.
A staff interview with the Campus Life Enrichment Director confirmed that the policy and procedure manual has not been reviewed and updated to meet the new legislative requirements, in effect since July 2010. She confirmed that some policies have not been reviewed since 1995, that there are no goals and objectives in place and that there are no policies related to monitoring outcomes and reassessment of residents.
[O. Reg. 79/10, s. 30 (1)1.] (203)
2. A review of the plan of care for an identified resident revealed that the resident is to have exercises 3 or more times/week.
In review of the resident's Physiotherapy Resident Log for March 2012, the resident received treatment only 3 times and the resident's responses to treatment were not documented.
The Physiotherapist revealed that the resident often refuses treatment. However, he confirmed his expectation is that resident's responses to interventions/treatments are to be documented.
[O. Reg. 79/10, s. 30 (2)]
3. A review of policies and procedures revealed that the home was unable to demonstrate that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.
A review of the home's continence care policies, #202-26 and #202-25, dated July 2008, revealed that they do not meet the expectations in the regulations.
It is noted that the home has had some preliminary meetings related to falls prevention and management but the program has not been fully developed and implemented.
There is no documented evidence to support that there are written descriptions for each of the four required programs that include:
* goals and objectives;
* relevant policies, procedures,and protocols;
* methods to reduce risk and monitor outcomes; and
* protocols for referral of residents to specialized resources where required

The Director of Care confirmed that the home does not have organized programs with relevant policies and procedures in place for continence care and bowel management, falls prevention and management, skin and wound care and pain management.
[O. Reg. 79/10, s. 30 (1)1] (135)(137)(203)

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following subsections:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) 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. 31 (3).

Findings/Faits saillants :

1. A review of the staffing schedules from April 30, 2012 to May 27, 2012 (28 days) revealed that there were numerous shifts not filled when nursing and personal care staff did not come to work, despite the current back-up plan being utilized. Negative outcomes were noted, as documented in other findings contained within this inspection report, including baths and oral care not provided to residents.
The staffing clerk confirmed that there were 76.75 shifts not covered in the 28 day period. This equates to being short 2.74 personal support worker shifts per day.
The Director of Care acknowledged that the information provided by the staffing clerk was accurate.
[O. Reg. 79/10, s.31.(3)(d)] (203)
2. There is no documented evidence to support that the staffing plan has been evaluated at least annually.
The Director of Care acknowledged that although she was aware that there was a requirement to do an annual evaluation, the home does not have a formal evaluation process for staffing.
[O. Reg. 79/10, s.31.(3)(e)] (203)

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following subsections:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. Residents expressed concerns, to inspectors, about not receiving two baths per week.
Personal Support Workers expressed concerns, throughout the inspection, about residents not being bathed twice per week, due to staffing shortages.
A review of bathing records in Point of Care revealed that each resident has not been bathed, at a minimum, twice a week during the month of May. There have been 71 baths missed in the first 27 days of May 2012.
The Director of Care (DOC) and Acting Chief Executive Officer (ACEO) reviewed this data with inspector #128.
The DOC confirmed that these numbers were accurate. She indicated that she was aware that baths were being missed but she had no idea that the numbers were this high. She indicated that the home had a process in place and that a form was to be submitted to her when baths were missed and that she then submitted the form to the Nursing Administrative Assistant/Staffing Clerk, who would in turn arrange for additional staff to come in to perform the missed baths. The DOC acknowledged that this process was not being followed and therefore, the missed baths were not being done.
[O. Reg. 79/10, s.33.(1)] (203)

Additional Required Actions:

CO # - 010 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. On May 14, 2012, during the initial home tour, hazardous chemicals were found in unlocked, unattended dirty utility rooms and spas.
On May 15, 2012, a spa room door was found ajar and unattended. Containers of hazardous substances were observed in the room.
On May 15, 2012, a hazardous seam sealer was observed sitting on the desk, in an office. This room is accessible to residents and was open and unattended.
On May 17, 2012, Chlorox disinfectant spray was observed twice in the washroom of a resident's room.
On May 17, 2012, an unlocked and unattended housekeeping cart containing hazardous chemicals was observed.
During interviews with the Building Services Director, on May 14, 15, and 17, 2012, he confirmed awareness that hazardous substances must be kept inaccessible to residents at all times.
Inspector #128, expressed concern that this had been identified during the April 27, 2012 complaint inspection and that inspectors were continuing to observe chemicals accessible to residents.
On May 17, 2012, the Acting CEO, confirmed her expectation that all doors where hazardous substances are stored are to be locked at all times when unattended. She stated new self closing/locking doors were on order. However, she acknowledged that all doors needed to be locked, in the meantime, when left unattended.
May 18, 2012, Inspector #203 observed hazardous substances in a spa room which was open and unattended.
A Personal Support Worker confirmed that the room was open and unattended.
On May 22, 2012, Inspector #128 showed the DOC a hazardous chemical, Chlorox disinfectant spray, sitting in the bathroom of a resident's room and explained why chemicals being accessible to residents is a risk and that they had been observed on an ongoing basis throughout the inspection. The DOC acknowledged that she understood the risk.
On May 28, 2012, Inspector # 203 observed a spa room with hazardous chemicals in it, open and unattended.
The home continued to be made aware of ongoing risks related to hazardous chemicals, throughout the inspection.

[O. Reg. 79/10, s.91] (135) (137) (203)

Additional Required Actions:

CO # - 011 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

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
(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. On May 22, 2012, at 17:28, Inspector #128 showed the DOC the Sterisol Therapeutic Oral Rinse, DIN #476781, that was accessible in a resident room, noting that it expired in 1993.
The DOC revealed that the oral rinse should have a prescription and that it should not be in a resident room, particularly since it had expired in 1993, and acknowledged that medications are expected to be locked.
[O.Reg. 79/10. s.129.(1) (a) (ii) and (iv)]
2. On May 24, 2012, Inspectors # 203 and # 137 accessed the Surplus Drug Storage Room, which revealed that the following medications were expired:
(1) Vaccine Fridge
Fluad - expired Date April 2012.
(2) Surplus Drug Storage Room
Senokot - expired February 2012;
Apo K - expired April 2012;
Allugel - expired 2011.
A registered nurse shared that it is the expectation of the night registered nurse to check for expiration dates when they do the ordering on Sunday nights. However, this is not documented in the routines and both the registered nurse and DOC confirmed this.
[O.Reg. 79/10, s.129 (1) (a) (iv)]
3. On May 25, 2012, Inspectors # 128 and # 137 accessed a Chart Room, containing Surplus Drug Storage cupboards, which revealed that the following medications were expired:
Potassium Chloride Liquid – expired March 2012;
Fleet Enemas (4) – expired February 2012.
The DOC was notified.
[O.Reg. 79/10, s.129 (1) (a) (iv)]
4. On May 25, 2012, Inspectors # 128 and # 137 accessed a Chart Room. The room is accessible to all staff as they are aware of the keypad code.
Inspectors observed an unlocked treatment cart containing prescription creams, ointments and dressing supplies.
The Acting Assistant Director of Care (AADOC) was made aware of the risk and shared that the carts are supposed to be locked.
[O.Reg. 79/10, s.129 (1) (a) (ii)]

Additional Required Actions:

CO # - 012 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following subsections:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. A review of the training records revealed that direct care staff have not been trained, prior to performing their responsibilities, in the following areas, since the implementation of the LTCHA, July 2010:
•Falls Prevention and Management – 60 of 60 direct care staff have not had training;
•Skin and Wound Care - 60 of 60 direct care staff have not had training;
•Continence Care and Bowel Management - 44 of 60 direct care staff have not had training;
•Pain Management, including pain recognition of specific and non-specific signs of pain - 60 of 60 direct care staff have not had training.
The Human Resources Director confirmed the accuracy of these training records.
[O. Reg. 79/10, s.221(1) 1, 2, 3 and 4]

Additional Required Actions:

CO # - 013 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. There is no documented evidence to support that improvements made through the quality improvement and utilization review system are communicated to Residents' Council, Family Council and staff of the home on an ongoing basis.
The Campus Life Enrichment Director, Director of Care and the Acting CEO confirmed that improvements have not been shared with any of these groups.
[O. Reg. 79/10, s. 228. 3]
2. There is no documented evidence to support that the home's quality improvement and utilization review system has policies, procedures and protocols and a process to identify initiatives for review.
The Acting CEO confirmed that the Quality Council does "project work" but there is not a process in place to identify initiatives for review. She also shared that the home has received training related to a Quality Management Program, funded through the LHIN. She acknowledged, however, that the quality improvement program has not been customized to the home nor has it been fully implemented.
[O. Reg. 79/10, s. 228. 1]

Additional Required Actions:

CO # - 014 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following subsections:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

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

Findings/Faits saillants :

1. A review of the Agency Staff binder revealed that there is no evidence to support that staff from two employment agencies were trained prior to performing their responsibilities.
Fifteen agency staff, nine of whom are registered nursing staff, have been hired in 2012. Eight of these staff were hired post March 2012 when the home received a compliance order from the MOHLTC to ensure that all staff were trained prior to performing their duties. There is no documented evidence to support that the staff have been trained nor that the compliance order was complied with.
The Director of Care confirmed that there are no orientation checklists &/or written documentation to confirm that any of these staff were trained prior to performing their responsibilities.
[LTCHA, 2007, S.O. 2007, c.8,76 (2) 1, 2, 3 ,4, 5, 6, 7, 8, 9, 10, and 11]
2. Interviews with staff and a review of the training records revealed that direct care staff have not been trained, prior to performing their responsibilities, in the following areas since the implementation of the LTCHA, July 2010:
Mental health issues/Behaviour Management training – 23 of 105 have not had training (the home requires all staff to take this training.
Palliative care training – 60 of 60 have not had training.
[LTCHA, 2007, S.O.2007, c. 8, s.76 (7) 2, 3 and 5]
3. Interviews with staff and a review of the training records revealed that all staff have not been trained, prior to performing their responsibilities, in the following areas since the implementation of the LTCHA, July 2010:
•The Residents' Bill of Rights – 40 of 105 staff have not had training.
•The long-term care home's mission statement - 88 of 105 staff have not had training.
•The long-term care home's policy to promote zero tolerance of abuse and neglect of residents - 39 of 105 staff have not had training.
•The duty under section 24 to make mandatory reports - 105 of 105 staff have not had training.
•The protections afforded by section 26 – whistle blowing protection - 39 of 105 staff have not had training.
•The long-term care home's policy to minimize the restraining of residents – 87 of 105 have not had training.
•Fire prevention and safety – 32 of 105 staff have not had training.
•Emergency and evacuation procedures - 56 of 105 staff have not had training.
•Infection prevention and control – 62 of 105 have not had training
- 85 of 105 staff have not had training related to handwashing.
•All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities - 66 of 105 have not had training.
A staff interview with the Human Resources Director confirmed the accuracy of these training records. She also confirmed that mandatory training has not been enforced as being mandatory for staff.
[LTCHA, 2007, S.O.2007, c. 8, s. 76 (2) 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10]

Additional Required Actions:

CO # - 015 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following subsections:

s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Findings/Faits saillants :

1. The home does not have screening protocols and assessment and reassessment instruments available for the pain management program and the continence care and bowel management program as evidenced by:
A review of the progress notes for an identified resident revealed that the resident fell and was found complaining of pain and appeared to be in a lot of pain. There was no evidence of further pain assessment. The resident was hospitalized and after the resident returned to the home, there is no evidence that a pain assessment was completed.

A review of the progress notes for an identified resident revealed that the resident was complaining of pain, rating pain 10 out of 10. The on-call physician was called. There was no evidence that a pain assessment was completed. The next day the resident went to hospital with an injury.
The DOC confirmed that the home does not have assessment and reassessment instruments in place to identify and manage pain for residents.

A clinical record review for an identified resident revealed that his/her continence has not been reassessed using a reassessment instrument.
The Director of Care confirmed that the home does not have continence care assessment and reassessment instruments in place.

[O. Reg. 79/10, s.48 (2) (a) and (b)] (203)

Additional Required Actions:

CO # - 016 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care
Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. An identified resident was observed to have a skin condition and was self-treating it.
A staff interview with a registered nurse confirmed that the registered staff were aware that the resident had an ongoing skin condition but acknowledged that an assessment had never been done. After inspector #128 identified this, a registered nurse stated that it was a good idea that somebody look at it and indicated that he/she would add it to the doctor's book so that it could be assessed by the physician.
[O. Reg. 79/10, s. 50 (2) (b) (i)]
2. A clinical record review for an identified resident revealed that there is no evidence to support that a skin assessment was completed for this resident post return from hospital.
The Resident Assessment Instrument (RAI) coordinator acknowledged that a head to toe assessment was not completed when the resident returned from hospital and that one should have been completed.
Additionally, there is no evidence to support that any assessments of the wound were completed using a clinically appropriate assessment instrument for this resident, post hospitalization and return to the home.
A registered practical nurse confirmed that there is no evidence to support that assessments of the wound were completed using a clinically appropriate assessment instrument.
The DOC acknowledged that the home's expectation is that wound care assessments are completed for all residents with altered skin integrity.
[O. Reg. 79/10, s. 50 (2) (a) (ii) and 50 (2) (b) (i)] (137)
3. A review of an identified resident's Skin and Wound Assessments revealed that they were not conducted weekly by a member of the registered nursing staff.
The Director of Care and a registered practical nurse confirmed that weekly wound care assessments have not been conducted.
The Acting Assistant Director of Care shared that it is the expectation that the registered staff conduct weekly wound care assessments. She also confirmed that the registered staff require education related to wound care to ensure consistent assessments.

[O. Reg. 79/10, s.50(2)(b)(iv)]

Additional Required Actions:

CO # - 017 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. There is no documented evidence to support that a monthly audit is undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies.
The Director of Care confirmed that the home does not do a monthly audit of the daily count sheets of controlled substances.
[O. Reg. 79/10, s. 130. 3.]
2. On May 16, 2012, Inspector #128 requested to use the Therapy room/Doctor's office, to access the internet. A maintenance worker volunteered to open the room with his/her key. Cupboards in the room were observed unlocked and contained bottles of Zylocaine, Baxedine, Dovidine, Peroxide and tubes of Polysporin.
The Building Services Director confirmed awareness that the only people who were allowed to have access to medications were registered nursing staff and indicated that he would be discussing the issue with the Director of Care as his staff needed to be able to access this room in case of an emergency.

3. On May 17, 2012, the Therapy room/Doctor's office was observed open and accessible to residents and staff. A resident was using the telephone and a personal support worker was working at a desk in the room.
Cupboards were observed unlocked and contained bottles of Zylocaine, Baxedine, Dovidine, Peroxide and tubes of Polysporin.
The Director of Care was notified of the ongoing risk related to medications accessible and that this had been previously identified on April 27, 2012, during a complaint inspection. She acknowledged that the home was aware that only registered staff were allowed to have access to medications.

4. On May 18, 2012, Inspectors # 128 and # 137 observed the Nursing Supply Room, in the basement, open and unlocked. The room contained nursing supplies as well as medications.
The Acting CEO, who was in the room, confirmed that the server was in the room and that other staff had keys to the room, as well. She acknowledged that she was not aware that there were drugs in the room and that she would ensure only registered staff would have access to medications and they would be removed from the room.

5. On May 18, 2012, the Therapy room/Doctor's office was observed open and accessible to residents and staff, again and the same medications still accessible in the unlocked cupboards.
The Acting CEO had acknowledged 5 minutes previously that the home was taking action related to risks after Inspector #128 had relayed that inspectors were continuing to identify ongoing risks in the home. She also acknowledged that managers were also aware of ongoing risks being observed in the home and had brought these risk issues to her attention.

6. On May 25, 2012, Inspectors # 128 and # 137 accessed a Chart Room. The room is accessible to all staff as they are aware of the keypad code.
Two medication cupboards were observed unlocked and contained Koffex, Tylenol, Ferrous Gluconate, Senokot, Gravol suppositories, Allernix, Docusate Sodium, liquid Potassium Chloride, fleet enemas, Isopropyl Alcohol, Vitamin B12 injectable, prescription eye drops, prescription puffers, Resperidone liquid, Nitro Spray, prescription creams, Aspirin and Rhinaris nasal gel.
The AADOC was made aware of the risk and shared that the cupboards were supposed to be locked.

7. On May 30, 2012, Inspectors # 128 and # 203 accessed a Chart Room that is accessible to all staff. Inspectors observed two medication cupboards unlocked and containing all of the same medications noted from May 25, 2012.
The AADOC was made aware of the risk again and shared that the cupboards were supposed to be locked.
[O. Reg. 79/10, s. 130. 1. and 2. i.] (203) (128)

Additional Required Actions:

CO # - 018 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. A care plan review for an identified resident revealed that previous care plans have not been retained in the Point Click Care system. Previous care plans from 2010, 2011 and March 2012 have been replaced with May 2012 interventions for Nutrition Services and Program Support and the original record has not been maintained.
Staff interviews with the Life Enrichment Director, Resident Assessment Instrument (RAI) Coordinator and DOC revealed that they did not know how this could have happened, acknowledging that it would appear that the previous records were not locked in the computer system.
The DOC confirmed that the home's expectation is that resident records are maintained at all times.
[O. Reg. 79/10, s. 231 (a)]
2. A staff interview with the RAI coordinator revealed that the home's expectation is that the care plan in Point Click Care is reviewed and revised each quarter, within 2 weeks of when the MDS assessment is done. She acknowledged that the dates for care plan revision are inconsistent and "all over the map", after this was identified to the home by the MOHLTC inspectors. She confirmed that the care plans are not completed within the home's required time frames and that the new reassessment dates are then incorrect.
Residents written records are not not kept up to date at all times. Care plans for 7 residents were reviewed and it was noted that none of them were completed within the allotted time frame. As evidenced by the following example: one resident's care plan was started November 16, 2011 but not completed until February 19, 2012. The next care plan was documented to be initiated May 5, 2012 but is not yet completed.
The RAI coordinator confirmed that there were 45 care plans that were not current as of May 25, 2012.

[O. Reg. 79/10, s.231(b)] (135)

Additional Required Actions:

CO # - 019 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 218. Orientation
For the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training shall be provided:
1. The licensee's written procedures for handling complaints and the role of staff in dealing with complaints.
2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.
3. Cleaning and sanitizing of equipment relevant to the staff member's responsibilities. O. Reg. 79/10, s. 218.

Findings/Faits saillants :

1. A review of the training records revealed that all staff have not been trained in the following areas since the implementation of the LTCHA, July 2010, prior to performing their responsibilities:
•Written procedures for handling complaints and role of staff in dealing with complaints – 105 of 105 staff have not had training
•Safe use of equipment – 15 of 105 staff have not had training

The Human Resources Director confirmed the accuracy of these training and orientation records.

[O. Reg. 79/10, s.218. 1, and 2]

Additional Required Actions:

CO # - 020 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program Specifically failed to comply with the following subsections:

s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;
(c) that the local medical officer of health is invited to the meetings;
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(e) that a written record is kept relating to each evaluation under clause (d) 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. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

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

Findings/Faits saillants :

1. There is no documented evidence to support that symptoms indicating the presence of infection are monitored in accordance with evidence based practices, on every shift.
Inspector #135 and #137 were told during the initial tour of the home a tracking sheet was not used.
The AADOC confirmed that staff on every shift do not monitor symptoms of infection.
[O. Reg. 79/10, s.229(5)(a)] (135)
2. There is no documented evidence that staff, on every shift, record symptoms indicating the presence of infection in residents and take immediate action as required.
A Registered Practical Nurse expressed concern that the home does not have measures in place to monitor infections, including Tuberculosis. He/she stated that he/she was not told that a resident has Hepatitis C. He/she reported that if a resident has C-difficile then the staff communicate that at report but if you don't happen to be working that shift then you wouldn't be told about it. He/she reported that the home doesn't track MRSA or VRE.
The AADOC confirmed that symptoms are not recorded on every shift, except if the home experiences an outbreak.
[O. Reg. 79/10, s.229(5)(b)] (128) (203)
3. There is no documented evidence that the Infection Prevention and Control program is evaluated and updated at least annually.
The AADOC confirmed that the infection control program is not evaluated and updated annually.
[O. Reg. 79/10, s.229(2)(d]
4. There is no documented evidence of an interdisciplinary team approach in the co-ordination and implementation of the Infection Prevention and Control Program.
The AADOC, confirmed that there is no interdisciplinary team approach in the coordination of the program.
[O. Reg. 79/10, s.229(2)(a)]
5. On May 25, 2012, a personal support worker was observed carrying a meal tray down a hall. The prunes and four beverages were uncovered.
A staff interview with the Director of Nutrition Services confirmed that the expectation is that all food is to be covered while being transported in hallways.
[O. Reg. 79/10, s.229(4)]
6. A Registered Practical Nurse was observed administering medications to three residents. There was no hand washing or hand sanitizing observed being used, between residents, during the administration of medications.
The AADOC confirmed that staff are expected to wash their hands or use hand hygiene while administering medications.
[O. Reg. 79/10, s.229(4)]
7. Clinical record reviews were conducted for five residents and revealed that four of the five residents who were admitted in 2012, were not screened for tuberculosis within 14 days of admission.
One resident did not receive TB testing until 18 days post admission.
One resident did not receive TB testing until 19 days post admission.
One resident did not receive TB testing until 21 days post admission.
One resident did not receive TB testing until 28 days post admission.
It was confirmed by a Registered Practical Nurse that four of five residents were not screened for tuberculosis within 14 days of admission.
[O. Reg. 79/10, s.229(10)1]

Additional Required Actions:

CO # - 021 will be served on the licensee. Refer to the "Order(s) of the Inspector".

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection control program; there is an interdisciplinary approach in the co-ordination and implementation of the program; and that each resident is screened for tuberculosis within 14 days of admission, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

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

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

Findings/Faits saillants :

1. On May 17, 2012, an identified resident was observed receiving a treatment, by a registered nurse, in a public area. On May 28, 2012, two residents were observed receiving treatments being administered in a hallway and one of the resident's had their abdomen exposed.
The Director of Care acknowledged during an interview that this did not meet the home's expectation related to how residents were to be treated with respect and dignity and ensuring that every resident had the right to be be provided treatment in privacy.
[LTCHA, 2007, S.O. 2007, c.8, s.3(1)1. and 3(1)8.] (137) (203)

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 every resident is treated with respect and dignity and that every resident is afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. A clinical record review for an identified resident revealed that an individualized plan to promote continence has not been developed for this resident. The plan of care states toilet at established times; ac, pc meals and qhs.
The RAI coordinator acknowledged that residents' plans of care are not individualized although voiding patterns are monitored upon admission for 3 days. She stated that all the plans of care include interventions to toilet residents ac, pc meals and HS or every 2 hours. She revealed that they are not based on an individual assessment of each resident but she stated that was a really good idea.
[O.Reg. 79/10, s. 51 (2) (b)]
2. A review of an identified resident's plan of care revealed the resident is to be toileted ac, pc meals and qhs.
A staff interview revealed that upon admission, residents are monitored for a 3 day voiding pattern and 7 day bowel pattern. Once completed, the form is given to the RAI Coordinator to develop the plan of care.
There is no documented evidence that the assessment considers or includes the resident's individualized toileting pattern.
The Director of Care and a Personal Support Worker confirmed that toileting routines are not individualized.

[O.Reg. 79/10, s. 51 (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident who is incontinent has an individualized plan, as part of his or her plan of care to promote and manage bowel and bladder continence based on an assessment and that the plan is implemented, to be implemented voluntarily.

WN #23: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following subsections:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. A review of the Restraint Policy # 203-49, revised December 2010, reveals that a physician or Registered Nurse Extended Class will prescribe a physical restraint.
A review of an identified resident's clinical record revealed that there is no physician order for a specific type of restraint. It was also noted that the policy is not in compliance and implemented in accordance with all applicable requirements under the Act nor is it complied with.
The Director of Care confirmed that the policy was not complied with as there is no physician order for this specific restraint, which the resident is not able to independently unfasten. She also acknowledged that the policy does not meet current legislative requirements.
[LTCHA, 2007, S.O. 2007, c.8, s.29(1)(b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with the Act and regulations and that the policy is complied with, to be implemented voluntarily.

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. A review of the clinical record for an identified resident revealed that a specific restraint has not been identified as being used and there is no documented evidence to support that the resident is being monitored at least every hour while being restrained.
The Director of Care and a Personal Support Worker confirmed that the resident has not been monitored every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
This finding has previously been issued and re-issued as an unmet criterion under the Long Term Care Facilities Program Manual.
[O. Reg. 79/10, s.110(2)3]
2. An identified resident was observed, on May 18 and May 24, 2012, with a specific type of restraint in place.
A review of the resident's clinical record revealed that there is no documentation of a physician's order to apply this specific type of restraint.
The Director of Care confirmed that the home did not have an order and that staff had applied the physical device being used to restrain the resident, without an order from the physician.
[O. Reg. 79/10, s.110(2)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 staff only apply a physical device to restrain a resident after it has been ordered by a physician or registered nurse in extended class and that the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose, to be implemented voluntarily.

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following subsections:

s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).

s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. There is no documented evidence that the licensee has developed an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.
The Director of Care confirmed that the home has not developed an interdisciplinary medication management system.
[O. Reg. 79/10, s.114(1)]
2. A review of the Administration of Medications/Nursing Department Policy # 201-56, revealed that it was last revised on April 1,1999 and does not reflect the current medication practices of the home.
A review of the Medical Pharmacy Policy Manual revealed that policies were revised in 2005 and 2009.
The Director of Care acknowledged that the policies are not current and do not reflect the home's current practice, to ensure the accurate acquisition, dispensing, receipt, storage, administration, destruction and disposal of all drugs used in the home.
[O. Reg. 79/10, s.114(2)]
3. A review of the Administration of Medications/Nursing Department Policy # 201-56, revealed that it was last revised on April 1, 1999.
The Director of Care confirmed that the policy has not been evaluated and updated in accordance with evidence-based practices.
[O. Reg. 79/10, s.114(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 the licensee develops an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. The plan must also ensure that policies are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, destruction and disposal of all drugs used in the home. The plan must also ensure that the policies and protocols are developed, implemented, evaluated and updated in accordance with evidence -based practices and/or prevailing practices, to be implemented voluntarily.

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

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).

Findings/Faits saillants :

1. A review of an identified resident's clinical record revealed a physician's order to change wound dressings twice weekly and PRN, applying antibiotic ointment. There is documented evidence on the Treatment Administration Record (TAR), that the antibiotic is applied daily, with the dressing change.
There is no documented evidence of a physician order to increase the frequency of applying the antibiotic and the dressing changes.
A registered practical nurse confirmed that the order, to increase the frequency of applying antibiotic, had not been obtained.
A registered nurse confirmed that he/she had received a verbal order from the physician but he/she forgot to write the order.
[O.Reg. 79/10, s.131(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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following subsections:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. There is no documented evidence to support that every medication incident involving a resident and every adverse drug reaction is reported to the pharmacy service provider.
The Director of Care confirmed that all medication incidents and adverse drug reactions are not reported to the pharmacy service provider.
[O. Reg. 79/10, s.135(1)(b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that that every medication incident involving a resident and every adverse drug reaction is reported to the pharmacy service provider, to be implemented voluntarily.

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following subsections:

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;
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and
(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. A review of the Point of Care ADL - Oral Care report revealed, for a 27 day period, oral care/cleaning of dentures was not provided both in the morning and evening for the following residents:
Resident #1 - did not receive twice daily care for 6 days and no oral care was provided on one day;
Resident #2 -did not receive twice daily care for 10 days and no oral care was provided on one day; and
Resident #3- did not receive twice daily care 8 times.
The Director of Care confirmed her expectation is that residents are to receive daily mouth care in both the morning and evening.
[O. Reg. 79/10, s. 34 (1) (a)] (135)
2. Record reviews for three residents, for the last year, revealed they were not offered an annual dental assessment and other preventive dental services.
The Director of Care confirmed she was unaware of the requirement that residents be offered an annual dental assessment and other preventive dental services as required.
[O. Reg. 79/10, s. 34 (1) (c)] (137)

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 mouth care in the morning and evening, including the cleaning of dentures; and is offered an annual dental assessment and other preventive dental services, to be implemented voluntarily.

WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. A review of the clinical record and a critical incident report revealed that an identified resident was transferred to hospital. The Critical Incident was not submitted to the MOHLTC until 2 days later.
The Director of Care acknowledged that the MOHLTC Director was not notified of the incident, within the required time frame of one business day.
[O. Reg. 79/10, s.107(3)4.] (203)
2. A clinical record review revealed that an identified resident fell and was transferred to hospital.
The critical incident report regarding the resident's fall was submitted to the MOHLTC 22 days later and not within the required time frame of one business day.
The Director of Care confirmed the home did not inform the MOHLTC Director within the one business day.

[O. Reg. 79/10, s.107(3)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 critical incidents are submitted to the Director within the required time frames, to be implemented voluntarily.

WN #30: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following subsections:

s. 213. (4) The licensee shall ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section,
(a) has at least one year of experience working as a registered nurse in the long-term care sector;
(b) has at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and
(c) has demonstrated leadership and communication skills. O. Reg. 79/10, s. 213 (4).

Findings/Faits saillants :

1. A review of staffing records, with the Human Resources Director, revealed that the Director of Care did not have 3 years experience working as a Registered Nurse, prior to being hired as the DOC, in December 2011.
The Acting Administrator acknowledged that this amount of experience would not meet the requirement of at least three years experience working as a registered nurse in a managerial or supervisory capacity.
[O.Reg.79/10,s. 213(4)(b)] (203)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director of Care has the experience required working in a managerial or supervisory capacity in a health care setting, to be implemented voluntarily.

WN #31: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following subsections:

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. A review of clinical records for an identified resident revealed the resident has had four falls since admission.
For two (50%) of those falls, post-falls assessments were not conducted using a clinically appropriate assessment instrument that is specifically designed for falls.
The Director of Care confirmed her expectation is that a post falls assessment using a clinically appropriate assessment instrument is completed following a resident's fall.
[O. Reg. 79/10, 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 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, to be implemented voluntarily.

WN #32: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. A review of the information required to be posted in the home revealed the home's license was not posted or communicated to residents.
The Administrative Assistant confirmed the home's license was not posted.
[O.Reg. 79/10, s. 225 (1) 2.]

WN #33: 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 subsections:

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. A Residents' Council representative confirmed the Council was unaware of the requirement that the licensee was to respond to Residents' Council in writing within 10 days related to concerns or recommendations. The representative confirmed that this does not happen.
The Campus Life Enrichment Director acknowledged she was unaware of the requirement that the licensee must respond in writing within 10 days. The licensee has failed to respond to council despite documentation of concerns related to hollering residents, burnt out lights, window stops and the home being short staffed.
[LTCHA, 2007 S.O. 2007, c.8, s.57(2)]

WN #34: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network.
4. Charges for goods and services provided without the resident's consent.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The home's Purchase of Services Agreement with residents and resident charges records were reviewed and it was confirmed that residents are charged $10/month rental fee for a specific safety device.
The Acting CEO confirmed she was not aware that this safety device cannot be charged to residents.
The home acknowledged that they would stop charging for the device and that they would reimburse any residents who have been charged.
[O. Reg 79/10, s.245.1] (128)

WN #35: 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 subsections:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3);
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any;
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The home has failed to document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.
A Residents' Council representative confirmed, the satisfaction survey results from November 2011, have not been documented and shared with the Council and the home has not asked Councils' advice about the survey results.
The Campus Life Enrichment Director and the Acting CEO confirmed that the home has not documented and made available the results of the current satisfaction survey to Residents' Council in order to seek their advice.
[LTCHA, 2007 S.O. 2007, c.8, s. 85 (4) a] (128)

WN #36: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. A review of the minutes from Family Council meetings revealed that there is no evidence to support that the licensee responds in writing within 10 days of receiving concerns or recommendations from Family Council. There has not been a written response provided to Family Council since June 15, 2011.
An interview with a Family Council representative confirmed that responses from the licensee are not provided.
The Campus Life Enrichment Director confirmed she was unaware of the requirement that the licensee must respond in writing within 10 days.
[LTCHA, 2007, S.O. 2007, c.8,s.60(20] (203)

WN #37: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following subsections:

s. 136. (5) The licensee shall ensure,
(a) that the drug destruction and disposal system is audited at least annually to verify that the licensee's procedures are being followed and are effective;
(b) that any changes identified in the audit are implemented; and
(c) that a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 136 (5).

Findings/Faits saillants :

1. There is no documented evidence to support that the drug destruction and disposal system is audited at least annually.
The Director of Care confirmed that an annual audit has not occurred.
[O. Reg. 79/10, s.136(5)(a)]

WN #38: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following subsections:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. There is no documented evidence of an annual interdisciplinary team meeting to evaluate the effectiveness of the medication management system.
The Director of Care confirmed that the home has not done a medication management system evaluation that includes all the required disciplines, annually.
[O. Reg. 79/10, s.116(1)]

WN #39: The Licensee has failed to comply with O.Reg 79/10, s. 123. Emergency drug supply
Every licensee of a long-term care home who maintains an emergency drug supply for the home shall ensure,
(a) that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator are kept;
(b) that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply;
(c) that, at least annually, there is an evaluation done by the persons referred to in clause (a) of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs; and
(d) that any recommended changes resulting from the evaluation are implemented. O. Reg. 79/10, s. 123.

Findings/Faits saillants :

1. There is no documented evidence to support that at least annually, the home does an evaluation of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs.
The Director of Care confirmed that the annual evaluation of the emergency drug supply has not occurred.
[O. Reg. 79/10, s.123(c)]

WN #40: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The Minimizing Restraining of Residents: Use of Restraints policy # 203-49 was reviewed and noted to be last revised in December 2010.
There is no documented evidence that the licensee, once in every calendar year, conducts an evaluation to determine the effectiveness of the restraint policy.
The Director of Care confirmed that an evaluation of the policy has not occurred.
[O. Reg. 79/10, s.113(b)]

WN #41: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices;
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device;
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others;
(d) types of physical devices permitted to be used;
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented;
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. A review of the Restraint Policy # 203-49, dated December 2010, revealed that the types of physical devices permitted to be used are not identified.
The Director of Care confirmed that the policy is not current and does not identify the types of restraints permitted in the home.
[O. Reg. 79/10, s.109(d)]

WN #42: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. Observation of the privacy curtain in an identified resident's bedroom revealed that it does not provide full privacy as it does not surround the bed.
Interviews with the Director of Care and Building Services Director revealed that the expectation is that each resident is provided privacy and that the privacy curtain fully surrounds the bed.
[O. Reg. 79/10, s. 13]

WN #43: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs
Specifically failed to comply with the following subsections:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The registered dietitian confirmed that an identified resident was not referred for assessment of poor fluid intake (less than 750 mls./day in 3 consecutive days) as per the Food and Fluid Intake and Monitoring policy-Nursing #202-66, dated May 2012.
During an interview and review of this same policy, the registered dietitian confirmed that she was not involved in the development of the policy and she had never seen the policy before. She stated it was her understanding that residents are referred to the dietitian for low fluid intake of 1200 mls/day or less after 3 consecutive days.
The Director of Care confirmed the development and implementation of the hydration policy, in May 2012, was not done in consultation with registered dietitian.
[O. Reg. 79/10, s. 68 (2) (a)]
2. A review of 15 clinical records revealed that all 15 residents did not have their heights taken annually.
A registered practical nurse confirmed that residents heights are taken on admission only.
The dietitian and Director of Care confirmed their expectations are that residents' heights are taken annually.
[O. Reg. 79/10, s. 68 (2) (e)(ii)] (135)

WN #44: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. A Resident Council representative revealed that dining and snack service times have not been reviewed with the Residents' Council.
The Nutrition Services Director confirmed the dining and snack service times have not been reviewed with the Residents' Council.
[O.Reg.79/10,s.73(1)2.]
2. A registered practical nurse was observed standing to feed an identified resident. The resident was in an unsafe position and at a potential risk for choking.
The registered practical nurse acknowledged that the home's expectation is that staff are to sit to feed residents and ensure that residents are in a safe feeding position.
[O.Reg.79/10,s.73(1)10.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

CORRECTED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 75.	CO #002	2012_095105_0021	128

Issued on this 12th day of July, 2012

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

Ruth Hildebrand

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) :	RUTH HILDEBRAND (128), BONNIE MACDONALD (135), MARIAN MACDONALD (137)
Inspection No. / No de l'inspection :	2012_087128_0010
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Date of Inspection / Date de l'inspection :	May 14, 15, 16, 17, 18, 22, 23, 24, 25, 26, 28, 29, 30, 31, Jun 1, 4, 5, 6, 7, 8, 11, 12, 13, 14, 19, 20, 21, 28, 2012
Licensee / Titulaire de permis :	RITZ LUTHERAN VILLA R.R. 5, MITCHELL, ON, N0K-1N0
LTC Home / Foyer de SLD :	RITZ LUTHERAN VILLA PART LOT 16, CON 2, LOGAN TWN, R.R. #5, MITCHELL, ON, N0K-1N0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BOB PETRUSHEWSKY

To RITZ LUTHERAN VILLA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA, 2007 S.O. 2007, c.8, s. 6.
The plan must include confirmation with immediate dates that the written plans for 8 identified residents:
-were reviewed and/or revised to ensure that the plans of care provide clear direction to staff;
-assessments were completed and are collaborative and integrated;
- staff were made aware of the care set out in the plan of care so that the care is provided to the residents;
-the care set out in the plans has been reviewed and revised when the care needs have changed or not been effective with different approaches considered in the revision of the plan of care.
The plan will also include how plans of care, for all residents of the home, will be reviewed and revised on an ongoing basis when the resident's care needs change or the care set out in the plan is no longer necessary and how the licensee will ensure that the care set out in the plan will be provided to the residents.

Please submit the plan in writing to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King Street, 4th Floor, London, ON N6B 1R8, by email, at ruth.hildebrand@ontario.ca, by July 18, 2012.

Following this review and plan submission, the licensee shall submit a monthly report to the Ministry identifying progress related to ensuring plans of care are updated and maintained . The action plan will contain timelines for completion of the actions required and identify who is accountable for the task.
Please submit the action plan in writing to Long Term Care Homes Inspector, Ruth Hildebrand, by email, at ruth.hildebrand@ontario.ca. by the last day of each month, commencing August 2012.

Grounds / Motifs :

1. Two written notifications of non-compliance and two voluntary plans of correction have previously been issued under LTCHA, 2007 S.O. 2007, c.8, s.6, as well as one unmet criterion under the Long-Term Care Facilities Program Manual.
2. An identified resident fell sustaining an injury, while walking without being supervised.
A record review for this resident revealed that the resident had a post falls assessment had been completed the week before after a previous fall. The post falls assessment indicated the factor contributing to the fall was the resident's unsteady gait and the action plan was to monitor resident and supervise with walking.
The plan of care, however, does not have interventions documented to ensure staff are aware that the resident is to be monitored and supervised while walking.
The Director of Care confirmed the resident's plan of care does not provide clear directions to recreation staff and others who provide direct care to the resident, related to it not indicating that the resident is to be monitored and supervised with walking.
[LTCHA, 2007 S.O. 2007, c.8, s.6.(1)(c)] (135)
3. A clinical record review was completed, for an identified resident who has had several falls, to determine if the care plan provides clear directions for care staff and others who provide direct care to the resident.
The resident fell and was re-assessed by Restorative Care and the assessment indicated the following:

Due to the resident's inability to transfer safely with 2 people while using the standard walker, it is suggested that the resident be a 2 person transfer and no walker to stand and pivot into a chair. The resident appears to have no concept of what to do with the walker at this time.
In review of the resident's plan of care, the interventions for transfer of the resident stated the following: Continue to transfer the resident with 2 persons and walker. Instruct the resident on proper walker usage.
Staff interviews with personal support workers confirmed that staff were transferring the resident from the bed to chair using a walker.
The Restorative Care Coordinator confirmed that the resident's plan of care did not provide clear directions to staff and others who provide direct care to the resident when it stated that resident could transfer using a walker.
[LTCHA, 2007 S.O. 2007, c. 8, s. 6 (1) (c)] (135)
4. A clinical record review for an identified resident revealed that there is no evidence to support that the resident was assessed and the plan of care reviewed and revised post hospitalization.
A staff interview with the RAI Coordinator confirmed that this resident's plan of care was not reviewed and revised when the resident's care needs changed.
[LTCHA, 2007, S.O. 2007, c.8,s.6(10)(b)] (128)
5. A review of the plan of care for an identified resident revealed that there are no documented oral assistance interventions noted on the plan of care to provide direction to staff in caring for this resident.
A registered practical nurse confirmed that the plan of care does not provide clear direction to staff as it does not contain any interventions related to oral care.
[LTCHA, 2007, S.O. 2007, c.8, s.6(1)(c)] (137)
6. The plan of care for an identified resident, noted the resident is to receive 1:1 exercises, 1-3x /week. However, a review of Resident's Physiotherapy Resident Logs for 2012, revealed these exercises have not been recorded as occurring since December, 2011.
The Physiotherapist revealed that the resident no longer requires this exercise. He confirmed the plan of care should have been revised as the care set out in the plan was no longer necessary.
[LTCHA, 2007 S.O. 2007, c.8, s.6.(10) (b)] (135)
7. A review of the clinical record for an identified resident revealed that the resident has been experiencing a wound(s) for the past four months. Clear direction has not been provided to staff as goals and interventions related to wounds are not identified on the plan of care.
The Director of Care and a registered practical nurse confirmed that goals and interventions related to wounds were not identified on the plan of care. The ADOC shared that the registered staff were expected to include goals and interventions related to wounds in the plan of care.
[LTCHA, 2007, S.O. 2007, c.8, s.6(1)(c)] (137)
8. A clinical record review for an identified resident revealed that the plan of care related to activation did not provide staff with clear direction to identify what the resident was interested in when it stated "offer activity program directed toward specific interests/needs of resident". The resident's interests were not documented.
A review of the program records for this resident revealed that there has been no attendance at any activities in the month of May and only two "one on one" activities were offered.
Programs staff acknowledged that the resident won't come to the activities that they offer. The plan of care has not been revised even though the interventions related to activity patterns and pursuits have not been effective. There was no documentation to support that different approaches have been considered despite the fact that the resident does not attend activities.
The Campus Life Enrichment Director agreed that the care plan interventions were not individualized for this resident and the home needed to provide clear direction to staff. She also acknowledged that the interventions that the home was using were not working and this resident should have been reassessed.
[LTCHA, 2007, S.O. 2007, c.8, s.6(1)(c) and s.6(11)(b)] (128)
9. A review of an identified resident's clinical record revealed that the only documented restraint assessment was completed indicating a specific type of restraint to be used, related to falls. This assessment was not a collaborative assessment involving all aspects of care. There is still no physician order for this restraint and there is no documented evidence of restraint monitoring by any nursing staff.
The Director of Care confirmed that there has not been a collaborative assessment of this resident and that staff should have obtained a physician's order and should be monitoring the resident's restraint.

[LTCHA, 2007, S.O. 2007, c.8, s. 6 (4) (a)] (137)
10. A review of the plan of care for an identified resident revealed that a safety device is to be turned on. The care specified in the plan of care was not followed as the safety device was observed off on May 23, 2012 and twice on May 24, 2012.
A personal support worker acknowledged that he/she is aware that the safety device is to be turned on but he/she knows that staff don't always turn it on as he/she often finds it turned off.
The DOC acknowledged, May 24, 2012, that her expectation is that the plan of care is to be followed and that the safety device is turned on.
May 25, 2012 the safety device was observed turned off, again, despite the home being notified the day before.
[LTCHA, 2007, S.O. 2007, c.8, s. 6 (7)] (128)
11. An identified resident was observed in the hallway ambulating at 14:28. The resident has a safety device in place but it took staff 6 minutes to respond.
A personal support worker acknowledged that the resident was at risk of falling and that no staff were on the floor while report was being given. He/she indicated that report is supposed to start 5 minutes before end of shift so that staff would be available until 14:30 to cover the floor.
He/she acknowledged that this was a safety risk for this resident as the staff were aware that this resident is to be monitored any time the safety device goes off.
A registered practical nurse acknowledged that the expectation is that staff are to respond immediately when these safety devices sound. He/she also indicated that he/she really wasn't sure who was to be monitoring the floor while report was happening.
[LTCHA, 2007, S.O. 2007, c.8, s. 6 (7)] (128)
2. (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 18, 2012

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must conduct an immediate review of the care being provided to an identified resident to ensure compliance with LTCHA, 2007, c. 8, s. 19 (1) and that the resident is not neglected by the staff.
Once the review is completed the licensee must prepare, submit and implement a plan that includes confirmation that resident's plan of care has been reviewed/revised, as necessary to meet the care needs for this resident.
The plan will also include how the home will communicate with the resident and include his/her participation in decision making.
The plan must also include how the staff have been trained to treat this resident with courtesy and respect and in a way that fully recognizes his/her individuality and dignity.

Please submit the plan in writing to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King Street, 4th Floor, London, ON N6B 1R8, by email, at ruth.hildebrand@ontario.ca, by July 18, 2012.

Grounds / Motifs :

1. Two written notifications and a voluntary plan of correction have previously been issued related to LTCHA, 2007, c. 8, s. 19 (1).
2. All inspection team members observed an identified resident numerous times per day, each day throughout the inspection. Staff walking by the resident failed to respond to his/her requests. The pattern of inaction resulted in the resident not being provided adequate food and fluids. The resident is at high nutritional risk.
On May 17, 2012 the resident stated that he/she was hungry and a PSW advised the resident that he/she would have to wait until lunch for something to eat. No action was taken to provide the resident with something to eat until MOHLTC intervention was provided.
On May 17, 2012, the identified resident told Inspectors #128 and #137 that he/she wanted to go to bed. Four personal support workers were in the nursing station when Inspector #128 informed them that the resident wanted to go to bed. The PSW's laughed and said that there is no way that he/she will go lay down. They took no action to speak with the resident to see if he/she actually wanted to go to bed.
It was noted that the resident was not observed in any activities, throughout the inspection.
On May 24, 2012, the identified resident was observed refusing to go to the dining room for breakfast. Staff did offer him/her breakfast but a tray was not provided. The resident was offered juice from the morning snack cart but he/she refused it. He/she was not offered any other beverages or any food. At 10:58, the resident was provided with a preferred beverage after he/she told the DOC that he/she was thirsty.
A staff interview was conducted May 24, 2012 @ 11:00 with the Director of Care to determine expectations related to offering food to residents who don't eat their breakfast. She stated that the expectation is that residents are offered food at morning snack if they don't eat their breakfast. Inspector #128 informed the DOC that this resident did not have any breakfast and that he/she was not offered anything to eat at morning snack. The DOC expressed sadness at hearing this and provided the resident with more of the preferred beverage and a snack. Inspector #128 identified to the DOC that interventions that the home had in place were not working and that the home needed to reassess the resident.
On May 24, 2012 @ 14:20, a staff interview was held with the Acting CEO to advise her of ongoing significant risks being identified in the home, including that the above resident was being neglected. Inspector #128 informed the Acting CEO that this resident was not treated the same as other residents related to lack of activation, meals and fluids not being offered and staff not listening to the resident.
The Acting CEO expressed concern about what the inspector was telling her and was concerned that if the staff were ignoring this resident then they could be ignoring other residents, too. She agreed that the home needed to look at this resident with a new set of eyes.
Later the same day, the Director of Nutrition Services identified that she was aware that the home had not been monitoring this resident's food and fluid records like they should be when the resident hasn't been eating and drinking. She indicated that she was aware that this resident was below the fluid alert levels on certain days and that the home had not been meeting the resident's needs.
The DOC and the Director of Nutrition Services confirmed that the expectation was that all residents who did not come to the dining room were provided with a tray at meal time, including cognitively impaired residents who refuse a meal.
[LTCHA, 2007, c. 8, s. 19 (1)] (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 18, 2012

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must revise the policy to promote zero tolerance of abuse and neglect of residents, including the duty to make mandatory reports, to achieve compliance with LTCHA, 2007, S.O. 2007, c.8,s. 20(2).

Grounds / Motifs :

1. A review of the Abuse or Suspected Abuse of a Resident policy #102-06, dated October 2011, revealed that the policy does not reflect mandatory reporting to the MOHLTC. The time frames for investigation are also not in compliance with the LTCHA and Regulations.
The Acting CEO confirmed that the policy does not reflect expectations in the LTCHA and Regulations.
[LTCHA, 2007, S.O. 2007, c.8,s. 20(2)] (128)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 18, 2012

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 8(1) to ensure that there are policies implemented in accordance with applicable requirements under the Act and that they are complied with.
The plan must ensure how education will be provided to staff related to the implemented policies and how compliance will be monitored.

Please submit the plan in writing to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King Street, 4th Floor, London, ON N6B 1R8, by email, at ruth.hildebrand@ontario.ca, by July 18, 2012.

Grounds / Motifs :

1. The Monitoring Resident's Weight and Height, Nutrition Care policy #704-11b, dated December 2009, states: if a new weight represents a significant change of 5% or more in one month, 7.5% or more in 3 months and 10% or more in 6 months; nursing re-weighs residents to confirm the weight. This policy was not complied with when high risk residents were not re-weighed as of May 28, 2012 and had the following percentage weight losses in one month, since April 2012:
Resident #1 - 9.0%
Resident #2 -7.8%
Resident #3 -9.4%
Resident #4 - 9.1 %
Resident #5 -7.3%
The registered dietitian confirmed she often has to request that residents be re-weighed before assessing residents for weight loss.
The Director of Care confirmed, her expectation is that residents are re-weighed when there is a significant weight change of 5% or more in one month.
[O.Reg. 79/10, s.8(1)(b)] (135) (128)
2. A review of the Tray Service policy #703-06, dated May 2007, revealed that residents who are not in the dining room are to be provided a tray.
This policy has not been complied with for an identified resident who was observed without a tray and not in the dining room at meal time.
The Director of Nutrition Services confirmed that her expectation is that the home's policy is followed and that all residents are to be provided a tray at meals when they are not in the dining room.
[O.Reg. 79/10, s.8(1)(b)] (128)
3. A review of clinical records for an identified resident revealed that the resident has had six falls since August 2011.
The Falls Prevention and Management policy #202-69, dated July 2008 was not complied with when the resident fell and the following information was not completed as part of the post falls assessment:
-Notify the attending Physician and ensure immediate treatment after the fall;
-Notify the resident's family resident has fallen;
-Complete fall incident report in detailed progress notes;
-Investigate the contributing factors associated with the fall and modify care plan as indicated.
A post falls assessment tool noted "no side rails" as the contributing factor for the resident's fall, while the plan of care does not reflect that resident requires side rails while in bed.
The Director of Care confirmed her expectation is that Falls Prevention and Management policy #202-69 July 2008, is complied with when doing a post falls assessment.
[O.Reg. 79/10s.8(1)(b)] (135)
4. There is no documented evidence that there is a plan, policy, protocol, procedure, strategy or system in place that is in compliance and implemented in accordance with all applicable requirements under the Act to address residents being offered an annual dental assessment.
Three of three residents reviewed related to dental assessments were not provided an annual dental assessment.

The Director of Care confirmed this and acknowledged that she was not aware that this was a requirement.
[O. Reg. 79/10, s.8(1)(a)] (135) (137)
5. The home has failed to ensure that the policy on Skin Care and Preventing, #202-87, dated March 2008, was complied with. This was evidenced by a clinical record review for an identified resident that revealed a skin assessment was not completed for this resident post two hospitalizations.
The RAI coordinator confirmed that the policy was not followed when registered staff did not conduct a head to toe assessment upon the resident's return from hospital.
[O. Reg. 79/10, s.8(1)(b)] (128)
6. The Nutrition Assessment and Risk Identification, Nutrition Care #704-04 policy, dated November 2008, states:
resident who has experienced a change of health that affects nutrition status i.e. re-admission from hospital is referred to the RD using the Nutritional Referral form Appendix B.
This policy was not complied with when an identified resident returned from hospital and was not referred to the Dietitian.
The Dietitian confirmed that the resident had not been referred for a nutritional assessment after returning from the hospital.
[O.Reg. 79/10, s.8(1)(b)] (135)
7. The Monitoring Resident's Weight and Height, Nutrition Care policy, #704-11b, dated December 2009, states: each resident's height is taken at the following times: on admission and annually thereafter.
In record reviews, the Height monitoring policy was not complied with when 15 of 15 (100%) residents reviewed did not have their heights taken annually.
[O.Reg. 79/10, s.8(1)(b)] (135)
8. The AM. Care/HS. Care policy #203-61, dated April 1999, revealed that residents are to receive denture care AM. and HS.
The policy was not complied with when 3 of 3 residents were not provided denture care in the morning and evening, May 1-27, 2012.
The Director of Care confirmed the policy was not complied with when the three residents were not provided dental/oral care twice daily. [O.Reg.79/10, s. 8 (1)(b)](137)
The Director of Care also confirmed that policy # 203-61, AM.Care/HS. Care, dated April 1999 was not updated to reflect current legislative requirements to include residents with their own teeth, needing to receive twice daily mouth care.
[O.Reg.79/10, s. 8 (1)(a)] (135)
9. A review of the Medical Pharmacies Readmission of Residents from Hospital Policy # 7-4 revealed that all readmission orders are to be written on the "Physician's Order" sheet or "One Write Admission Form".
A clinical record review revealed that an identified resident returned from hospital in the evening and the accompanying hospital Physician Orders were not transcribed onto the home's physician order sheet or onto the "One Write Admission Form". The orders were not processed until the next afternoon and signed by only one registered staff member.
There is no documented evidence that the orders were checked and co-signed by a second registered staff member.
The Director of Care confirmed that a member of the registered nursing staff didn't check and co-sign the orders and that policy was not complied with.
[O. Reg. 79/10, s.8(1)b] (137)
10. A review of the Administration of Medications/Nursing Department Policy # 201-56, dated December 1998/revised April 1, 1999 revealed that all residents transferred to an acute care hospital will have new orders written upon return.
This policy was not complied with as evidenced by: a review of the Best Possible Medication History - Physician's orders for for an identified resident revealed documentation to "Continue all previous orders". There is no documented evidence that new orders were written upon return.
The Director of Care confirmed that new orders had not been written and that the policy was not complied with.
[O. Reg. 79/10, s.8(1)(b)] (137)
11. There is no documented evidence to support that there are policies related to the Infection Prevention and

Control program, including but not limited to the infection prevention and control team, program evaluation and daily monitoring of infections.
The DOC and ADOC confirmed that policies are not in compliance with the LTCHA and regulations related to the Infection Prevention and Control program.
[O. Reg. 79/10, s.8(1)(a)] (137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2012

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

The licensee must achieve compliance with O. Reg. 79/10, s. 17 (1) by installing a resident-staff communication and response system that is available in every area accessible by residents, including the four identified areas in the grounds for this order.

Grounds / Motifs :

1. On May 14, 23 and 24, 2012, it was observed that the resident-staff communication "call bell" system was not easily accessible in the rooms of three residents.
The Director of Care confirmed that the expectation is that resident's "call bells" must be easily accessible to residents in their rooms, at all times.
[O.Reg.79/10,s.17.(1)(a)] (135)
2. During the initial tour of the home on May 14, 2012, it was observed that the west wing lounges and north wing lounges, on both floors, are not equipped with a resident-staff communication and response system that is available and accessible to residents.
The Building Services Director acknowledged awareness that the home needed to have call bells in all areas accessible to residents and that they needed to be installed in the West lounge on first and second floors, as well as the North lounge on second floor and the physio treatment area, North first floor.
[O.Reg.79/10,s.17.(1)(e)] (137) (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2012

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

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

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

The licensee must achieve compliance with O. Reg. 79/10, s. 26 (3) by ensuring that plans of care are developed based on an interdisciplinary assessment for the residents identified in the grounds for this order and for all residents on an ongoing basis.

Grounds / Motifs :

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

1. Two written notices of non-compliance and one voluntary plan of correction have been issued previously related to O.Reg.79/10,s.26 (3).
2. A record review completed on May 23, 2012, for an identified resident, revealed the resident was admitted more than a year ago. At the time of the inspection, there was no plan of care for this resident related to recreation and social activity patterns or pursuits.
The Campus Life Enrichment Director confirmed the resident has not had a recreation and social activity plan of care developed, since admission, to direct staff providing resident care.
[O.Reg.79/10,s.26 (3)16.] (135)
3. An identified resident's clinical record revealed that there was not an interdisciplinary assessment as the only discipline involved in the assessment with respect to safety risks was nursing.
The physiotherapist confirmed that physiotherapy services are not consulted/contacted related to interdisciplinary assessment of safety risks.
[O. Reg. 79/10, s.26(3)19] (137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 18, 2012

Order # /
Ordre no : 007

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 26 (4) to ensure that the registered dietitian who is a member of the staff of the home,
a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses nutritional status, including height, weight and any risks relating to nutrition care as well as hydration status and any risks relating to hydration.

The home must also identify in the plan that education was provided to the registered nursing staff and the registered dietitian related to interdisciplinary communication. The licensee must also identify the methods outlining how ongoing assessment, referral and communication will occur as well as the name of the person(s) accountable for the tasks and monitoring.

Please submit the plan in writing to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King Street, 4th Floor, London, ON N6B 1R8, by email, at ruth.hildebrand@ontario.ca, by July 18, 2012.

Grounds / Motifs :

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

1. A written notification and voluntary plan of correction were previously issued under O. Reg. 79/10, s.68(2)d related to lack of monitoring and evaluation of inadequate fluid intake and subsequent hospitalization of a resident.
2. An identified resident's average daily fluid intake in a 5 day period was reviewed from the Point of Care fluid intake records. They revealed an average intake of 597 mls./day or 45.8 % of resident's daily fluid requirement of 1305 mls./day as noted in the plan of care. The resident's poor fluid intake was also identified by the Dietitian in a MDS assessment.
The Registered Dietitian confirmed that the resident was not referred for assessment when there was a significant change in hydration status; i.e. resident's fluid intake for a 5 day period was less than 750 mls./day for 3 consecutive days. Resident was not referred to the Dietitian as per the Food and Fluid Intake and Monitoring policy-Nursing #202-66, May 2012.
The Director of Care confirmed her expectation is that residents are referred to the Dietitian after 3 consecutive days of low fluid intake of less than 750 mls/day.
[O. Reg.79/10 s. 26 (4)(a)] (135)
3. An identified resident returned to the home from a hospital admission. The resident's nutritional status was not assessed by the Dietitian upon return from the hospital, even though there was a significant change in health status.
The Dietitian confirmed that the resident's nutritional status and/or any risks related to nutrition were not assessed.
[O. Reg. 79/10, s. 26 (4)(a)] (135)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2012

Order # /
Ordre no : 008

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

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 must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 30 (1).
1. The plan must ensure that the following interdisciplinary programs are developed and implemented in the home:
a) A falls prevention and management program to reduce the incidence of falls and the risk of injury.
b) A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
c) A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
d) A pain management program to identify pain in residents and manage pain.
e) A recreation and social activities program that is organized to meet the interests of all residents in the home.
2. 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.
3. 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.
4. 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.
5. The licensee shall keep a written record relating to each evaluation 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.

The plan must include how staff will be provided education for each of these programs including immediate education related to communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.

Please submit the plan in writing to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King Street, 4th Floor, London, ON N6B 1R8, by email, at ruth.hildebrand@ontario.ca, by July 18, 2012.

Following this review and plan submission, the licensee shall submit a monthly report to the Ministry identifying progress related to ensuring the required programs are developed and implemented . The action plan will contain timelines for completion of the actions required and identify who is accountable for the task. Please submit the action plan in writing to Long-Term Care Homes Inspector, Ruth Hildebrand, by email, at ruth.hildebrand@ontario.ca. by the last day of each month, commencing August 2012.

Grounds / Motifs :

1. One written notification of non-compliance and one voluntary plan of correction have previously been issued related to O. Reg. 79/10, s. 30 (1).
2. A review of the Campus Life Enrichment policy and procedure manual revealed that it has not been updated to reflect the LTCHA and Regulations. There are no goals and objectives nor policies related to monitoring outcomes and ensuring that residents are reassessed with resident's responses to interventions documented.
A staff interview with the Campus Life Enrichment Director confirmed that the policy and procedure manual has not been reviewed and updated to meet the new legislative requirements, in effect since July 2010. She confirmed that some policies have not been reviewed since 1995, that there are no goals and objectives in place and that there are no policies related to monitoring outcomes and reassessment of residents.
3. A review of policies and procedures revealed that the home was unable to demonstrate that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

A review of the home's continence care policies, #202-26 and #202-25, dated July 2008, revealed that they do not meet the expectations in the regulations.

It is noted that the home has had some preliminary meetings related to falls prevention and management but the program has not been fully developed and implemented.
There is no documented evidence to support that there are written descriptions for each of the four required programs that include:
* goals and objectives;
* relevant policies, procedures,and protocols;
* methods to reduce risk an monitor outcomes; and
* protocols for referral of residents to specialized resources where required
The Director of Care confirmed that the home does not have organized programs with relevant policies and procedures in place for continence care and bowel management, falls prevention and management, skin and wound care and pain management.
[O. Reg. 79/10, s. 30 (1)1] (135)(137)(203) (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2012

Order # /
Ordre no : 009

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) 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. 31 (3).

Order / Ordre :

The licensee must complete a comprehensive assessment of staffing plans to achieve compliance with Reg. 79/10, s. 31 (3). Once the assessment is done, strategies to hire staff must be pursued to ensure that there is a back-up plan in place for nursing and personal care staff that addresses situations when staff cannot come to work.

Following this review/assessment the licensee shall submit a monthly report to the Ministry identifying progress related to hiring of nursing and personal care staff. Additionally, the licensee will report the number of shifts that were not filled. The action plan will contain time lines for completion of the actions required and identify who is accountable for the task. Please submit the action plan in writing to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King Street, 4th Floor, London, ON N6B 1R8, by email, at ruth.hildebrand@ontario.ca., by the last day of each month, commencing July 2012.

Grounds / Motifs :

1. One written notification and one voluntary plan of correction have been previously identified related to O. Reg. 79/10, s. 31 (3).
2. A review of the staffing schedules from April 30, 2012 to May 27, 2012 (28 days) revealed that there were numerous shifts not filled when nursing and personal care staff did not come to work, despite the current back-up plan being utilized. Negative outcomes to residents were noted as documented in other findings contained within this inspection report.
The staffing clerk confirmed that there were 76.75 shifts not covered in the 28 day period. This equates to being short 2.74 personal support worker shifts per day.
The Director of Care acknowledged that the information provided by the staffing clerk was accurate.
[O. Reg. 79/10, s.31.(3)(d)] (203) (128)
3. There is no documented evidence to support that the staffing plan has been evaluated at least annually.
The Director of Care acknowledged that although she was aware that there was a requirement to do an annual evaluation, the home does not have a formal evaluation process for staffing.
[O. Reg. 79/10, s.31.(3)(e)] (203) (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 18, 2012

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 010

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee must achieve compliance with O. Reg. 79/10, s. 33 (1) to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.
The licensee shall complete a comprehensive review of bathing schedules and documentation to identify gaps in recording of baths. Additionally, the licensee must provide education to nursing and personal care staff to ensure that they are aware of documentation expectations. The licensee must also evaluate the system that is in place related to identification of missed baths and subsequent rescheduling at an alternate time.
Following this review, the licensee shall submit a monthly report to the Ministry identifying progress related to ensuring residents are being bathed at a minimum of twice per week. The action plan will contain timelines for completion of the actions required and identify who is accountable for the task. Please submit the action plan in writing to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King Street, 4th Floor, London, ON N6B 1R8, by email, at ruth.hildebrand@ontario.ca., by the last day of each month, commencing July 2012.

Grounds / Motifs :

1. One written notification and one voluntary plan of correction have been previously issued related to O. Reg. 79/10, s. 33 (1)
2. Residents expressed concerns, to inspectors, about not receiving two baths per week.
Personal Support Workers expressed concerns, throughout the inspection, about residents not being bathed twice per week, due to staffing shortages.
A review of bathing records in Point of Care revealed that each resident has not been bathed, at a minimum, twice a week during the month of May. There have been 71 baths missed in the first 27 days of May 2012.
The Director of Care (DOC) and Acting Chief Executive Officer (ACEO) reviewed this data with inspector #128. The DOC confirmed that these numbers were accurate. She indicated that she was aware that baths were being missed but she had no idea that the numbers were this high. She indicated that the home had a process in place and that a form was to be submitted to her when baths were missed and that she then submitted the form to the Nursing Administrative Assistant/Staffing Clerk, who would in turn arrange for additional staff to come in to perform the missed baths. The DOC acknowledged that this process was not being followed and therefore, the missed baths were not being done.
[O. Reg. 79/10, s.33.(1)] (203) (128)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 18, 2012

Order # / Ordre no : 011

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

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 91 to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. The plan must include confirmation that a policy related to hazardous substances has been developed and when and how staff will receive education related to this risk.

Please submit the plan in writing to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King Street, 4th Floor, London, ON N6B 1R8, by email, at ruth.hildebrand@ontario.ca, by July 18, 2012.

Grounds / Motifs :

1. On May 14, 2012, during the initial home tour, hazardous chemicals were found in unlocked, unattended dirty utility rooms and spas.
On May 15, 2012, a spa room door was found ajar and unattended. Containers of hazardous substances were observed in the room.
On May 15, 2012, hazardous seam sealer was observed sitting on the desk, in an office. This room is accessible to residents and was open and unattended.
On May 17, 2012, Chlorox disinfectant spray was observed twice in the washroom of a resident's room.
On May 17, 2012, an unlocked and unattended housekeeping cart containing hazardous chemicals was observed.
During interviews with the Building Services Director, on May 14, 15, and 17, 2012, he confirmed awareness that hazardous substances must be kept inaccessible to residents at all times.
Inspector #128, expressed concern that this had been identified during the April 27, 2012 complaint inspection and that inspectors were continuing to observe chemicals accessible to residents.
On May 17, 2012, the Acting CEO, confirmed her expectation that all doors where hazardous substances are stored are to be locked at all times when unattended. She stated new self closing/locking doors were on order. However, she acknowledged that all doors needed to be locked, in the meantime, when left unattended.
May 18, 2012, Inspector #203 observed hazardous substances in a spa room which was open and unattended. A Personal Support Worker confirmed that the room was open and unattended.
On May 22, 2012, at Inspector #128 showed the DOC a hazardous chemical, Chlorox disinfectant spray, sitting in the bathroom of a resident's room and explained why chemicals being accessible to residents is a risk and that they had been observed on an ongoing basis throughout the inspection. The DOC acknowledged that she understood the risk.
On May 28, 2012, Inspector # 203 observed a spa room with hazardous chemicals in it, open and unattended. The home continued to be made aware of ongoing risks related to hazardous chemicals, throughout the inspection.
[O. Reg. 79/10, s.91] (137) (203) (128) (135)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 18, 2012

Order # /
Ordre no : 012

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

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(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).

Order / Ordre :

The licensee must take immediate action to achieve compliance with O. Reg. 79/10, s. 129 (1) to ensure:
(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, and
(iv) complies with manufacturer's instructions for the storage of the drugs.

Grounds / Motifs :

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

1. One written notification and one voluntary plan of correction have previously been issued related to Reg. 79/10, s. 129 (1).
2. On May 22, 2012, Inspector #128 showed the DOC the Sterisol Therapeutic Oral Rinse, DIN #47678, that was accessible in an identified resident's room, noting that it expired in 1993.
The DOC revealed that the oral rinse should have a prescription and that it should not be in a resident room, particularly since it had expired in 1993, and acknowledged that medications are expected to be locked.
[O.Reg. 79/10. s.129.(1) (a) (ii) and (iv)] (128)
3. On May 24, 2012, Inspectors # 203 and # 137 accessed a Surplus Drug Storage Room, which revealed that the following medications were expired:
(1) Vaccine Fridge
Fluad - expired Date April 2012.
(2) Surplus Drug Storage Room
Senokot - expired February 2012;
Apo K - expired April 2012;
Allugel - expired 2011.
A registered nurse shared that it is the expectation of the night registered nurse to check for expiration dates when they do the ordering on Sunday nights. However, this is not documented in the routines and both the registered nurse and the DOC confirmed this.
[O.Reg. 79/10, s.129 (1) (a) (iv)] (137)
4. On May 25, 2012, Inspectors # 128 and # 137 accessed a Chart Room, containing Surplus Drug Storage cupboards, which revealed that the following medications were expired:
Potassium Chloride Liquid – expired March 2012;
Fleet Enemas (4) – expired February 2012.
The DOC was notified.
[O.Reg. 79/10, s.129 (1) (a) (iv)] (128)
5. On May 25, 2012, Inspectors # 128 and # 137 accessed a Chart Room. The room is accessible to all staff as they are aware of the keypad code.
Inspectors observed an unlocked treatment cart containing prescription creams, ointments and dressing supplies.
The Acting Assistant Director of Care (AADOC) was made aware of the risk and shared that the carts are supposed to be locked.
[O.Reg. 79/10, s.129 (1) (a) (ii)] (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 04, 2012

Order # /
Ordre no : 013

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee must immediately initiate that staff who provide direct care to residents receive training in the areas mention below to achieve compliance with O. Reg. 79/10, s. 221 (1):
1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.

The licensee shall submit a monthly report to the Ministry identifying progress related to ensuring that direct care staff are provided with training. The action plan will contain timelines for completion of the actions required and identify who is accountable for the task.
Please submit the action plan in writing to Ruth Hildebrand, Long Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King Street, 4th Floor, London, ON N6B 1R8, by email, at ruth.hildebrand@ontario.ca. by the last day of each month, commencing August 2012.

Grounds / Motifs :

1. A review of the training records revealed that direct care staff have not been trained, prior to performing their responsibilities, in the following areas, since the implementation of the LTCHA, July 2010:
•Falls Prevention and Management – 60 of 60 direct care staff have not had training;
•Skin and Wound Care - 60 of 60 direct care staff have not had training;
•Continence Care and Bowel Management - 44 of 60 direct care staff have not had training;
•Pain Management, including pain recognition of specific and non-specific signs of pain - 60 of 60 direct care staff have not had training.
The Human Resources Director confirmed the accuracy of these training records.
[O. Reg. 79/10, s.221(1) 1, 2, 3 and 4] (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 04, 2012

Order # /
Ordre no : 014

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 228. Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 228 to ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.

Please submit the plan in writing to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King Street, 4th Floor, London, ON N6B 1R8, by email, at ruth.hildebrand@ontario.ca, by July 18, 2012.

Grounds / Motifs :

1. There is no documented evidence to support that the home's quality improvement and utilization review system has policies, procedures and protocols and a process to identify initiatives for review.
The Acting CEO confirmed that the Quality Council does "project work" but there is not a process in place to identify initiatives for review. She also shared that the home has received training related to a Quality Management Program, funded through the LHIN. She acknowledged, however, that the quality improvement program has not been customized to the home nor has it been fully implemented.
[O. Reg. 79/10, s. 228. 1] (128)
2. There is no documented evidence to support that improvements made through the quality improvement and utilization review system are communicated to Residents' Council, Family Council and staff of the home on an ongoing basis.
The Campus Life Enrichment Director, Director of Care and the Acting CEO confirmed that improvements have not been shared with any of these groups.
[O. Reg. 79/10, s. 228. 3] (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2012

Order # /
Ordre no : 015

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

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee must immediately initiate that staff receive training, prior to performing their responsibilities, in the areas mentioned below to achieve compliance with LTCHA, 2007, S.O. 2007, c. 8, 76 (2) 1, 2, 3 ,4, 5, 6, 7, 8, 9, 10, and 11:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

The licensee shall submit a monthly action plan report to the Ministry identifying progress related to training of existing and new staff. The action plan will contain timelines for completion of the actions, including the numbers of existing staff who have been provided with the above required training and identify who is accountable for the task(s).
Please submit the action plan in writing to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King Street, 4th Floor, London, ON N6B 1R8, by email, at ruth.hildebrand@ontario.ca., by the last day of each month, commencing August 2012.

Grounds / Motifs :

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

1. There has been one written notification and one compliance order previously identified related to O. Reg. 79/10, s.76.(2)
2. A review of the Agency Staff binder revealed that there is no evidence to support that staff from two employment agencies were trained prior to performing their responsibilities.
Fifteen agency staff, nine of whom are registered nursing staff, have been hired in 2012. Eight of these staff were hired post March 2012 when the home received a compliance order from the MOHLTC to ensure that all staff were trained prior to performing their duties. There is no documented evidence to support that the staff have been trained nor that the compliance order, due April 9, 2012, was complied with.
The Director of Care confirmed that there are no orientation checklists &/or written documentation to confirm that any of these staff were trained prior to performing their responsibilities.
[LTCHA, 2007, S.O. 2007, c.8,76 (2) 1, 2, 3 ,4, 5, 6, 7, 8, 9, 10, and 11] (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 04, 2012

Order # /
Ordre no : 016

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 48 (2).
The plan must:
(a) provide for screening protocols; and
(b) provide for assessment and reassessment instruments;
for the following interdisciplinary programs:
a) A falls prevention and management program to reduce the incidence of falls and the risk of injury.
b) A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
c) A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
d) A pain management program to identify pain in residents and manage pain.

Please submit the plan in writing to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King Street, 4th Floor, London, ON N6B 1R8, by email, at ruth.hildebrand@ontario.ca, by July 18, 2012.

Grounds / Motifs :

1. The home does not have screening protocols and assessment and reassessment instruments available for the pain management program and the continence care and bowel management program as evidenced by:
A review of the progress notes for an identified resident revealed that the resident fell and was found complaining of pain and appeared to be in a lot of pain. There was no evidence of further pain assessment. The resident was hospitalized and after the resident returned to the home there is no evidence that a pain assessment was completed.
2. A review of the progress notes for an identified resident revealed that the resident was complaining of pain, rating pain 10 out of 10. The on-call physician was called. There was no evidence that a pain assessment was completed. The next day the resident went to hospital with an injury.
The DOC confirmed that the home does not have assessment and reassessment instruments in place to identify and manage pain for residents.
3. A clinical record review for an identified resident revealed that his/her continence has not been reassessed using a reassessment instrument.
The Director of Care confirmed that the home does not have continence care assessment and reassessment instruments in place.
[O. Reg. 79/10, s.48 (2) (a) and (b)] (203) (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2012

Order # / Ordre no : 017

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 50 (2) that identifies how the home will ensure:
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff, (ii) upon any return of the resident from hospital,
(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, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
The plan must include confirmation with immediate dates that the assessments for the identified residents have been completed.

Please submit the plan in writing to , Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King Street, 4th Floor, London, ON N6B 1R8, by email, at ruth.hildebrand@ontario.ca, by July 18, 2012.

Grounds / Motifs :

1. An identified resident was observed to have a skin condition and was self-treating it.
A staff interview with a registered nurse confirmed that registered staff were aware that the resident had an ongoing skin condition but acknowledged that an assessment had never been done. After inspector #128 identified this, a registered nurse stated that it was a good idea that somebody look at it and indicated that he/she would add it to the doctor's book so that it could be assessed by the physician.
[O. Reg. 79/10, s. 50 (2) (b) (i)] (128)
2. A clinical record review for an identified resident revealed that there is no evidence to support that a skin assessment was completed for this resident post return from hospital.
The Resident Assessment Instrument (RAI) coordinator acknowledged that a head to toe assessment was not completed when the resident returned from hospital and that one should have been completed.
Additionally, there is no evidence to support that any assessments of the wound were completed using a clinically appropriate assessment instrument for this resident, post hospitalization and return to the home.
A registered practical nurse confirmed that there is no evidence to support that assessments of the wound were completed using a clinically appropriate assessment instrument.
The DOC acknowledged that the home's expectation is that wound care assessments are completed for all residents with altered skin integrity.
[O. Reg. 79/10, s. 50 (2) (a) (ii) and 50 (2) (b) (i)] (137) (128)
3. A review of an identified resident's Skin and Wound Assessments revealed that they were not conducted weekly by a member of the registered nursing staff.
The Director of Care and a registered practical nurse confirmed that weekly wound care assessments have not been conducted.
The Acting Assistant Director of Care shared that it is the expectation that the registered staff conduct weekly wound care assessments. She also confirmed that the registered staff require education related to wound care to ensure consistent assessments.
[O. Reg. 79/10, s.50(2)(b)(iv)] (137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2012

Order # /
Ordre no : 018

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must take immediate action to achieve compliance with O.Reg 79/10, s. 130.
The licensee must ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered.

The home must conduct a review of all staff who have keys to drug storage locations to ensure that drugs are only stored in areas that can be accessed by persons who may dispense, prescribe or administer drugs in the home and/or the Administrator.

Grounds / Motifs :

1. There is no documented evidence to support that a monthly audit is undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies.
The Director of Care confirmed that the home does not do a monthly audit of the daily count sheets of controlled substances.
[O. Reg. 79/10, s. 130. 3.] (137)
2. On May 16, 2012, Inspector # 128 requested to use the Therapy room/Doctor's office, to access the internet. A maintenance worker volunteered to open the room with his/her key. Cupboards in the room were observed unlocked and contained bottles of Zylocaine, Baxedine, Dovidine, Peroxide and tubes of Polysporin.
The Building Services Director confirmed awareness that the only people who were allowed to have access to medications were registered nursing staff and indicated that he would be discussing the issue with the Director of Care as his staff needed to be able to access this room in case of an emergency.
3. On May 17, 2012, the Therapy room/Doctor's office was observed open and accessible to residents and staff. A resident was using the telephone and a personal support worker was working at a desk in the room. Cupboards were observed unlocked and contained bottles of Zylocaine, Baxedine, Dovidine, Peroxide and tubes of Polysporin.
The Director of Care was notified of the ongoing risk related to medications accessible and that this had been previously identified on April 27, 2012, during a complaint inspection. She acknowledged that the home was aware that only registered staff were allowed to have access to medications.
4. On May 18, 2012, Inspectors # 128 and # 137 observed the Nursing Supply Room, in the basement, open and unlocked. The room contained nursing supplies as well as medications.
The Acting CEO, who was in the room, confirmed that the server was in the room and that other staff had keys to the room, as well. She acknowledged that she was not aware that there were drugs in the room and that she would ensure only registered staff would have access to medications and they would be removed from the room.
5. On May 18, 2012, the Therapy room/Doctor's office was observed open and accessible to residents and staff, again and the same medications still accessible in the unlocked cupboards.
The Acting CEO had acknowledged 5 minutes previously that the home was taking action related to risks after Inspector #128 had relayed that inspectors were continuing to identify ongoing risks in the home. She also acknowledged that managers were also aware of ongoing risks being observed in the home and had brought these risk issues to her attention.
6. On May 25, 2012, Inspectors # 128 and # 137 accessed a Chart Room. The room is accessible to all staff as they are aware of the keypad code.
Two medication cupboards were observed unlocked and contained Koffex, Tylenol, Ferrous Gluconate, Senokot, Gravol suppositories, Allernix, Docusate Sodium, liquid Potassium Chloride, fleet enemas, Isopropyl Alcohol, Vitamin B12 injectable, prescription eye drops, prescription puffers, Resperidone liquid, Nitro Spray, prescription creams, Aspirin and Rhinaris nasal gel.
The AADOC was made aware of the risk and shared that the cupboards were supposed to be locked.
7. On May 30, 2012, Inspectors # 128 and # 203 accessed a Chart Room that is accessible to all staff.
Inspectors observed two medication cupboards unlocked and containing all of the same medications noted from May 25, 2012.
The AADOC was made aware of the risk again and shared that the cupboards were supposed to be locked.
[O. Reg. 79/10, s. 130. 1. and 2. i.] (203) (128) (137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 04, 2012

Order # /
Ordre no : 019

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 231. Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Order / Ordre :

The licensee must conduct an immediate comprehensive review of the records management system to ensure compliance with O. Reg. 79/10, s. 231 so that:
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times.

Once the review is completed the licensee must prepare, submit and implement a plan that includes confirmation that resident records are being maintained for all residents. The plan will also include how care plans/plans of care for the 45 residents identified will be reviewed and revised and how they will be maintained on an ongoing basis.

Please submit the plan in writing to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King Street, 4th Floor, London, ON N6B 1R8, by email, at ruth.hildebrand@ontario.ca, by July 18, 2012.

Following this review and plan submission, the licensee shall submit a monthly report to the Ministry identifying progress related to ensuring plans of care/care plans are updated and maintained . The action plan will contain timelines for completion of the actions required and identify who is accountable for the task.
Please submit the action plan in writing to Long Term Care Homes Inspector, Ruth Hildebrand, by email, at ruth.hildebrand@ontario.ca. by the last day of the month, commencing August 2012.

Grounds / Motifs :

1. A care plan review for an identified resident revealed that previous care plans have not been retained in the Point Click Care system. Previous care plans from 2010, 2011 and March 2012 have been replaced with May 2012 interventions for Nutrition Services and Program Support and the original record has not been maintained. Staff interviews with the Life Enrichment Director, Resident Assessment Instrument (RAI) Coordinator and DOC revealed that they did not know how this could have happened, acknowledging that it would appear that the previous records were not locked in the computer system.
The DOC confirmed that the home's expectation is that resident records are maintained at all times.
[O. Reg. 79/10, s. 231 (a)] (128)

2. A staff interview with the RAI coordinator revealed that the home's expectation is that the care plan in Point Click Care is reviewed and revised each quarter, within 2 weeks of when the MDS assessment is done. She acknowledged that the dates for care plan revision are inconsistent and "all over the map", after this was identified to the home by the MOHLTC inspectors. She confirmed that the care plans are not completed within the home's required time frames and that the new reassessment dates are then incorrect.
Residents written records are not not kept up to date at all times. Care plans for 7 residents were reviewed and it was noted that none of them were completed within the allotted time frame. As evidenced by the following example: one resident's care plan was started November 16, 2011 but not completed until February 19, 2012. The next care plan was documented to be initiated May 5, 2012 but is not yet completed.
The RAI coordinator confirmed that there were 45 care plans that were not current as of May 25, 2012.
[O. Reg. 79/10, s.231(b)] (135) (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 18, 2012

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 020

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 218. For the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training shall be provided:
1. The licensee's written procedures for handling complaints and the role of staff in dealing with complaints.
2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.
3. Cleaning and sanitizing of equipment relevant to the staff member's responsibilities. O. Reg. 79/10, s. 218.

Order / Ordre :

The licensee must immediately initiate that staff receive training prior to performing their responsibilities in the areas mentioned below to achieve compliance with O. Reg. 79/10, s. 218:

The licensee shall submit a monthly action plan report to the Ministry identifying the progress made and numbers of staff who have been provided with training. The action plan will contain timelines for completion of the actions required and identify who is accountable for the task.
Please submit the action plan in writing to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King Street, 4th Floor, London, ON N6B 1R8, by email, at ruth.hildebrand@ontario.ca. by the last day of each month, commencing August 2012.

Grounds / Motifs :

1. A review of the training records revealed that all staff have not been trained in the following areas since the implementation of the LTCHA, July 2010, prior to performing their responsibilities:
•Written procedures for handling complaints and role of staff in dealing with complaints – 105 of 105 staff have not had training.
•Safe use of equipment – 15 of 105 staff have not had training.
The Human Resources Director confirmed the accuracy of these training and orientation records.
[O. Reg. 79/10, s.218. 1, and 2] (128)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 04, 2012

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 021

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 229 (5) to ensure that on every shift:
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required.
The plan must also outline how registered and non-registered staff will be provided education related to symptoms and monitoring the presence of infection.

Please submit the plan in writing to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King Street, 4th Floor, London, ON N6B 1R8, by email, at ruth.hildebrand@ontario.ca, by July 18, 2012.

Grounds / Motifs :

1. There is no documented evidence to support that symptoms indicating the presence of infection are monitored in accordance with evidence based practices, on every shift.
Inspector #135 and #137 were told during the initial tour of the home a tracking sheet was not used.
The AADOC confirmed that staff on every shift do not monitor symptoms of infection.
[O. Reg. 79/10, s.229(5)(a)] (135) (137)
2. There is no documented evidence that staff, on every shift, record symptoms indicating the presence of infection in residents and take immediate action as required.
A Registered Practical Nurse expressed concern that the home does not have measures in place to monitor infections, including Tuberculosis. He/she stated that he/she was not told that a resident has Hepatitis C. He/she reported that if a resident has C-difficile then the staff communicate that at report but if you don't happen to be working that shift then you wouldn't be told about it. He/she reported that the home doesn't track MRSA or VRE.
The AADOC confirmed that symptoms are not recorded on every shift, except if the home experiences an outbreak.
[O. Reg. 79/10, s.229(5)(b)] (203) (137) (128)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2012

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

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 Clerk
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 Clerk
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.

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

Ministère 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

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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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 28th day of June, 2012

Signature of Inspector / Signature de l'inspecteur : Ruth Hildebrand

Name of Inspector / Nom de l'inspecteur : RUTH HILDEBRAND

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