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) :	DIANA STENLUND (163), MELISSA CHISHOLM (188)
Inspection No. / No de l'inspection :	2012_139163_0038
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Nov 13, 14, 15, 16, 21, 22, 23, 28, Dec 3, 2012
Licensee / Titulaire de permis :	BOARD OF MANAGEMENT OF THE DISTRICT OF PARRY SOUND WEST 21 Belvedere Avenue, PARRY SOUND, ON, P2A-2A2
LTC Home / Foyer de SLD :	BELVEDERE HEIGHTS 21 BELVEDERE AVENUE, PARRY SOUND, ON, P2A-2A2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	DONNA DELLIO

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

Order / Ordre :

The licensee shall prepare, submit, and implement a plan for achieving compliance with s.24(1) to ensure that when a person has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The plan is to be submitted by December 11, 2012 to Long-Term Care Home's Inspector, Diana Stenlund, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 603, Sudbury, Ontario P3E 6A5. Fax# 705-564-3133

Grounds / Motifs :

1. LTCHA, 2007,S.O.2007,c.8,s.24(1) was previously issued as a WN and VPC in inspection # 2011-057163-0011, in August 2011.
1. The inspector reviewed documentation indicating that the licensee was made aware of an incident of staff to resident abuse involving staff member #500 and resident #11. This incident was not immediately reported to the Director.
The inspector reviewed documentation of an additional staff to resident incident of abuse that was reported to the licensee involving resident #16 and staff member #600. This incident was not immediately reported to the Director. The licensee failed to immediately report the suspicion and the information upon which it is based to the Director: 1) Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, 2) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.[LTCHA, 2007, S.O.2007,c.8,s.24(1)1,2] (163)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 21, 2012

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

and the

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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 3rd day of December, 2012

Signature of Inspector / Signature de l'inspecteur : Diana Stenlund, #163

Name of Inspector / Nom de l'inspecteur : DIANA STENLUND

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

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
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'Inspection
Nov 13, 14, 15, 16, 21, 22, 23, 28, Dec 3, 2012	2012_139163_0038	Complaint

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF PARRY SOUND WEST
21 Belvedere Avenue, PARRY SOUND, ON, P2A-2A2

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

BELVEDERE HEIGHTS
21 BELVEDERE AVENUE, PARRY SOUND, ON, P2A-2A2

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

DIANA STENLUND (163), MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'Inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), registered nursing staff, personal support workers (PSWs), registered dietitian (RD), maintenance staff, and residents.

During the course of the inspection, the inspector(s) walked through resident home areas and laundry room, observed meal service, observed staff to resident interactions and care, observed resident to resident behaviours, reviewed resident health care records, reviewed home policies and procedures, reviewed critical incident documentation and personnel files.

The following log numbers were reviewed as part of this inspection: S-001183-12, and S-001276-12.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Infection Prevention and Control

Medication

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The inspector reviewed documentation indicating that the licensee was made aware of an incident of staff to resident abuse involving staff member #500 and resident #11. This incident was not immediately reported to the Director.
The inspector reviewed documentation of an additional staff to resident incident of abuse that was reported to the licensee involving resident #16 and staff member #600. This incident was not immediately reported to the Director. The licensee failed to immediately report the suspicion and the information upon which it is based to the Director: 1) Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, 2) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. [LTCHA, 2007, S.O.2007,c.8,s.24(1)1,2]

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. 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. Inspector observed on November 14, 2012 on Maple unit that two residents were dressed in pyjamas at 16:23h, over an hour before supper meal service is scheduled to begin. Inspector spoke with the unit's RPN who identified that sometimes staff will get residents ready for bed early when they are short staffed. Inspector spoke with a PSW who identified that the one resident had a bath before supper and it was the unit's routine to put residents who have baths into pyjamas so they do not need to change them a second time after supper. When asked about the other resident, who had not received a bath, the PSW identified that this resident required changing and can sometimes have behaviours thus the resident was put into pyjamas to avoid potential conflicts after supper. Inspector reviewed both residents' plans of care and noted no direction, or preference of these residents to be dressed in pyjamas prior to supper. The licensee failed to ensure that resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity was fully respected and promoted. [LTCHA 2007, S.O. 2007, c.8, s.3(1)(1)]
2. On Friday August 31, 2012 the home was notified by the Public Health Unit (PHU) via fax of a suspected respiratory outbreak in the home. Staff member #300 reported to the inspector that the home received confirmation from the PHU by fax on Sunday September 02, 2012 of a respiratory outbreak. Supervisory staff member #400 reported to the inspector that the home closed Cedar and Maple units to visitors on Sunday September 02, 2012 and re-opened the units on Tuesday September 04, 2012. It was reported that the PHU did not instruct the home to close the units over that time period. The licensee has not ensured that every resident has the right to receive visitors of his or her choice and consult in private with any person without interference [LTCHA, 2007,S.O.2007,c.8s.3(1)14].

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 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, and every resident has the right to receive visitors of his or her choice and consult in private with any person without interference, to be implemented voluntarily.

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

Specifically failed to comply with the following 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. Inspector reviewed the health care record of resident #052. Inspector noted that the resident sustained two falls in October 2012, one requiring assessment at the local hospital. Inspector noted that no post-fall assessment was completed following the two falls in October. Inspector spoke with two registered nursing staff members who identified that as per the home's fall prevention program a post-fall assessment should be completed following every resident fall. The licensee failed to ensure that when a resident has fallen and where the condition or circumstances 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)]
2. Inspector reviewed the health care record of resident #051. Inspector noted that the resident sustained nine falls within an eleven day period. Inspector noted that only one post fall assessment was completed following one of the falls. No new interventions were implemented or trialed as a result of the post-fall assessment. Inspector spoke with two registered staff members who identified that as per the home's fall prevention program a post-fall assessment should be completed following every resident fall. The licensee failed to ensure that when a resident has fallen and where the condition or circumstances 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)]

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 and where the condition or circumstances require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. Inspector reviewed the health care record including MAR (medication administration record) sheets for resident #14. The MAR indicates that resident #14 is to receive medication for pain, by mouth, every four hours when needed. On two occasions, documentation showed that resident #14 received medication, po (by mouth) for pain, however the resident's response and the effectiveness of the medication was not found documented in their health care record. Inspector interviewed supervisory staff member #300 on Nov. 15, 2012 who confirmed that there was no documentation in the resident's health care record that reflected the resident's response and effectiveness of the medication provided on those occasions. The licensee has not ensured that, when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs. [O.Reg,79/10,s.143(a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 46. Every licensee of a long-term care home shall ensure that every member of the staff who performs duties in the capacity of registered nurse, registered practical nurse or registered nurse in the extended class has the appropriate current certificate of registration with the College of Nurses of Ontario. O. Reg. 79/10, s. 46.

Findings/Faits saillants :

1. Inspector reviewed the personnel file for staff #100. Inspector noted this staff member, who was working in the role of a registered practical nurse (RPN) did not have evidence of registration with the College of Nurses of Ontario (CNO). Inspector spoke with supervisory staff member #200 who was also unable to provide evidence of the staff's registration with the CNO. It was reported to the inspector by staff #200 that after further review staff #100 was not currently registered with the CNO. The licensee failed to ensure that every member of the staff who performs duties in the capacity of registered nurse, registered practical nurse or registered nurse in the extended class has the appropriate current certificate of registration with the CNO. [O. Reg. 79/10, s.46]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following subsections:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff.
2. Restrained, in any way, as a disciplinary measure.
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36.
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. Inspector walked onto Maple unit and noted resident #051 to be sitting in a wheelchair behind the nursing station desk. The resident's wheelchair was pushed up against the desk, preventing the resident from standing up. The resident's wheelchair brakes were applied and the half-doors blocking access to the nursing station were also closed. Further, inspector observed the resident to be agitated, pulling at items on the desk and moving around in the wheelchair. Inspector was initially unable to locate any nursing staff. Inspector walked the unit and located a PSW leaving the shower room. As this staff member left it was noted that resident #051's personal alarm was activated due to the resident leaning forward in their wheelchair. Inspector observed as the staff member de-activated the alarm and left the resident sitting in their wheelchair behind the desk as previously described. A second PSW returned to the nursing unit. The inspector spoke with the two PSWs who identified this resident is at high risk for falls as the resident tries to stand up without requesting assistance. The PSWs further explained that the resident cannot be supervised at all time as they need to provide care to other residents thus positioning the resident behind the desk to limit their mobility is for their safety. Inspector approached supervisory staff member #200 to express concerns about the resident being restrained behind the nursing desk by staff as a fall prevention strategy. It was identified that restraining the resident behind the nursing desk is not part of the resident's plan of care and once on the unit staff member #200 proceeded to remove the resident from the area. The licensee failed to ensure that no resident of the home is restrained, in any way, for the convenience of the licensee or staff. [LTCHA 2007, S.O. 2007, c.8, s.30(1)(1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following 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. On two different occasions while in the home, the inspector observed staff members not using proper techniques to assist residents with eating. On November 13, 2012 in the Cedar dining room at dinner, the inspector observed staff member #700 to be in a standing position while feeding resident #18 who was seated. On November 15, 2012 in the Cedar dining room at breakfast, the inspector observed staff member #800 to be standing while feeding residents #13 and #17 who were both seated. The licensee has not ensured that the home has a dining and snack service that includes proper techniques to assist residents with eating. [O. Reg. 79/10, s. 73 (1)10].

Issued on this 4th day of December, 2012

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

Diana Stenlund, #163