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), LAUREN TENHUNEN (196), MONIQUE BERGER (151)
Inspection No. / No de l'inspection :	2013_139163_0018
Log No. / Registre no:	S-000061-13
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 26, 2013
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

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

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:

Order # /
Ordre no : 001

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 shall prepare, submit and implement a written plan of correction for achieving compliance with regards to the following:

1) Ensure that the home's policy to "Minimize Restraints" is implemented with regards to applying and removal of the restraint, repositioning and monitoring the resident, and documenting the actions taken by staff with regards to restraints, and

2) Ensure that the home's policy on "Surveillance and Process of Data Collection" is implemented with regards to monitoring all residents for signs and symptoms of infection, and completing the "Daily Infection Control Surveillance Record", and

3) Ensure that the home's policy on screening and immunization of residents is implemented with regards to residents receiving Tuberculosis screening, and immunizations for Pneumoccocus, Tetanus, and Diphtheria according to the requirements set out in the legislation.

The plan is to be submitted to Diana Stenlund, Inspector, Ministry of Health and Long-Term Care, Sudbury Service Area Office, by August 02, 2013. Fax #705-564-3133.

Grounds / Motifs :

1. Inspector reviewed the document, "Policy to Minimize Restraints" and interviewed staff about residents who have restraints. The home's policy is explicit in directing staff to "maintain records related to the restraining of residents ...and related to all assessments, re-assessments and monitoring, including the resident's response". On page 7 of this policy, the policy states the home staff will receive training regarding the application and use of the restraint that includes: "that any resident with a restraint must be monitored at least every hour by a member of the registered staff or by another staff member as authorized by a member of the registered staff and that any resident with a restraint must be released from the device and repositioned every 2 hours". Staff reported to the inspector that there is a requirement to document that they have applied and removed the restraint, repositioned the resident who has the restraint, and that hourly checks are conducted on residents with restraints. Staff also reported to the inspector that they do not document consistently on these areas related to restraints. The licensee has not ensured that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, specifically in regards to maintaining records related to the restraining of residents, is in compliance with and is implemented in accordance with all applicable requirements under the Act; and complied with. (151)

2. Inspector audited resident restraint hourly monitoring flow sheets used to document the following: hourly checks of the resident with a restraint, application of the restraint, removal of the restraint, resident reaction to the restraint and repositioning or removal of the restraint every 2 hours. Inspector audited for the period of June 1-25, 2013 and reviewed 5 different resident restraint monitoring records. In 5 of 5 records, the inspector noted that there were entire shifts where documentation related to restraints was not found. In addition, 5 of the 5 records failed to document the resident's response to the restraint. Inspector also noted that staff were using the code "7" on the document. This code was not found in the form's legend or the home's policy. The licensee has not ensured that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, specifically regarding required documentation for those residents who have a restraint applied, is in compliance with and is implemented in accordance with all applicable requirements under the Act; and complied with.

(151)

3. Inspector reviewed the home's policy "Surveillance and Process of Data Collection": The policy directs staff to:
* monitor all residents for signs and symptoms of infection
* to complete the Daily Infection Control Surveillance Record (IPC:F-40.00 (a))
Inspector was unable to locate any completed Daily Infection Control Surveillance Records. The inspector interviewed a supervisory staff member who reported that there is very poor compliance to this policy and that staff are instead putting incidental notes on the unit reports.
Inspector reviewed the home's policy "Screening and Immunization". The policy states
"immunization and screening measures to be completed within 14 days of admission which include: if there is no record of Mantoux - then do the 1st step Mantoux and 2 weeks later the 2nd step", and "Mantoux results are examined 48-72 hours after the Mantoux is administered".
Inspector reviewed the health care records of 10 newly admitted residents in 2013 and noted the following:
a) 5 of 10 residents' records did not indicate that they received their Step 1 Mantoux within 14 days of admission (residents received Step 1 Mantoux 76, 25, 17, 35 and 21 days post admission)
b) 6 of 10 residents' records did not indicate that Step 2 Mantoux was administered within 14 days of Step 1
c) 4 of 10 residents' records did not indicate Diphtheria and Tetanus immunization were offered
d) 1 of 10 resident records did not indicate Pneumovax immunization was offered
The licensee has not ensured that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, specifically regarding documentation of daily infection control surveillance and the provision of resident immunization and tuberculosis screening, is in compliance with and is implemented in accordance with all applicable requirements under the Act; and complied with. (151)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 20, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

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

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 26th day of July, 2013

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 26, 2013	2013_139163_0018	S-000061-13	Resident Quality Inspection

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), LAUREN TENHUNEN (196), MONIQUE BERGER (151)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 17-21 and 24-27, 2013

Additional logs reviewed during the course of the RQI:
S-000207-13
S-000214-13
S-000226-13

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Associate Director of Care, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), Manager of Support Services, Manager of Activities, Manager of Maintenance Services, Infection Control Coordinator, Staff Training Consultant, dietary staff, housekeeping staff, Resident Council and Family Council representatives, residents and family members.

During the course of the inspection, the inspector(s) walked through resident home areas, observed staff to resident care and interactions, observed dining, reviewed various home policies and procedures, and reviewed various resident health care records.

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

Accommodation Services - Laundry

Accommodation Services - Maintenance

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
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Resident Charges
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector reviewed the home's policy "Surveillance and Process of Data Collection": The policy directs staff to:
* monitor all residents for signs and symptoms of infection
* to complete the Daily Infection Control Surveillance Record (IPC:F-40.00 (a))
Inspector was unable to locate any completed Daily Infection Control Surveillance Records. The inspector interviewed a supervisory staff member who reported that there is very poor compliance to this policy and that staff are instead putting incidental notes on the unit reports.
Inspector reviewed the home's policy "Screening and Immunization". The policy states "immunization and screening measures to be completed within 14 days of admission which include: if there is no record of Mantoux - then do the 1st step Mantoux and 2 weeks later the 2nd step", and "Mantoux results are examined 48-72 hours after the Mantoux is administered".
Inspector reviewed the health care records of 10 newly admitted residents in 2013 and noted the following:
a) 5 of 10 residents' records did not indicate that they received their Step 1 Mantoux within 14 days of admission (residents received Step 1 Mantoux 76, 25, 17, 35 and 21 days post admission)
b) 6 of 10 residents' records did not indicate that Step 2 Mantoux was administered within 14 days of Step 1
c) 4 of 10 residents' records did not indicate Diphtheria and Tetanus immunization were offered
d) 1 of 10 resident records did not indicate Pneumovax immunization was offered
The licensee has not ensured that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, specifically regarding documentation of daily infection control surveillance and the provision of resident immunization and tuberculosis screening, is in compliance with and is implemented in accordance with all applicable requirements under the Act; and complied with. [s. 8. (1)]

2. Inspector reviewed the document, "Policy to Minimize Restraints" and interviewed staff about residents who have restraints. The home's policy is explicit in directing staff to "maintain records related to the restraining of residents ...and related to all assessments, re-assessments and monitoring, including the resident's response". On page 7 of this policy, the policy states the home staff will receive training regarding the application and use of the restraint that includes: "that any resident with a restraint must be monitored at least every hour by a member of the registered staff or by another staff member as authorized by a member of the registered staff and that any

resident with a restraint must be released from the device and repositioned every 2 hours". Staff reported to the inspector that there is a requirement to document that they have applied and removed the restraint, repositioned the resident who has the restraint, and that hourly checks are conducted on residents with restraints. Staff also reported to the inspector that they do not document consistently on these areas related to restraints. The licensee has not ensured that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, specifically in regards to maintaining records related to the restraining of residents, is in compliance with and is implemented in accordance with all applicable requirements under the Act; and complied with. [s. 8. (1)]

3. Inspector audited resident restraint hourly monitoring flow sheets used to document the following: hourly checks of the resident with a restraint, application of the restraint, removal of the restraint, resident reaction to the restraint and repositioning or removal of the restraint every 2 hours. Inspector audited for the period of June 1-25, 2013 and reviewed 5 different resident restraint monitoring records. In 5 of 5 records, the inspector noted that there were entire shifts where documentation related to restraints was not found. In addition, 5 of the 5 records failed to document the resident's response to the restraint. Inspector also noted that staff were using the code "7" on the document. This code was not found in the form's legend or the home's policy. The licensee has not ensured that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, specifically regarding required documentation for those residents who have a restraint applied, is in compliance with and is implemented in accordance with all applicable requirements under the Act; and complied with. [s. 8. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. Inspector reviewed the home's policy "Recreation and Leisure Services - One on One Programming". Inspector noted that the policy states "One on one programming will be provided to residents unable or unwilling to participate in the home's group activities as identified on their plans of care" and "one on one programming will be a minimum of 2x per week". Inspector reviewed the health care record and care plan document for resident #8498 and noted that staff are directed to provide the resident with "one on one visits on his home area and use sensory stimulation". Inspector reviewed the resident's attendance in activation programs over a recent 3 month period and noted that resident received on average only 4 one on one programs per month and that there is no record that the resident received any sensory stimulation activity. Inspector interviewed a supervisory staff person in the Activity department who confirmed the home does have a Snoozelen program (sensory stimulation) for residents who are not able to actively participate in group activation and that resident #8498 was not one of the residents receiving formal sensory stimulation as required in their plan of care. The care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

2. Inspector reviewed the health care records of 10 residents for the provision of 2 baths per week during the month of May. The results showed 9 of 10 residents did not have documentation to support that the resident was offered, received or refused the 2 baths scheduled per week. The licensee has not ensured that the provision of the care set out in the plan of care is documented.
Inspector reviewed the home's policy, "Daily Care Flow Sheets" in regards to the documentation of resident care and baths. This policy directs staff to document resident baths provided and reason if unable to provide a bath. Inspector interviewed registered and non-registered nursing staff about the documentation of resident baths. Staff confirmed they were to document all baths received and, if the resident did not receive the bath, a reason for this was to be documented. The licensee has not ensured that the provision of care set out in the plan of care is documented. [s. 6. (9)]

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 for residents who cannot actively participate in group activation, specifically regarding resident #8498, that one on one visits and sensory stimulation is provided to the resident as specified in their plan, and the provision of care set out in the plan of care is documented, specifically regarding the provision or refusal of baths offered to residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector observed 4 used hair picks, 4 used combs and 1 used hairbrush in the drawer in tub room G034. All of these personal hair items were unlabelled. The licensee has not ensured that each resident of the home has his or her personal items, labelled within 48 hours of admission and of acquiring, in the case of new items [s. 37. (1) (a)]

2. Inspector found unlabelled personal items, including bars of soap and toothbrushes laying randomly on a counter in a resident's shared bathroom. The licensee has not ensured that each resident of the home has his or her personal items, labelled within 48 hours of admission and of acquiring, in the case of new items. [s. 37. (1) (a)]

3. Inspector toured the unit and noted that there was a hair brush and "rub-on" deodorant on the counter in the tub room on Oak. The hair brush was heavily clogged with hair and both the brush and the deodorant did not have a label on it to identify which resident it belonged to. The licensee has not ensured that each resident of the home has his or her personal items, labelled within 48 hours of admission and of acquiring, in the case of new items [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents' personal items are labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

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Specifically failed to comply with the following:

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; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(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. Inspector reviewed the health care record for resident #45136 who is documented to be at moderate nutritional risk. On June 24, 2013 the inspector noted that their weight was not yet recorded for the month of June 2013. Inspector observed on the front of the weight recording chart that resident's weights are "due by the 10th of each month". Inspector interviewed staff who confirmed that this resident's weight was not taken by the 10th of June as per the home's policy, with no apparent reason given. The licensee has not ensured that the programs include, 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. [s. 68. (2) (a)]

2. Inspector reviewed the health care record for resident #45144 who is documented to be at moderate nutritional risk. When the inspector reviewed the weight recording sheets on June 24th, 2013 for resident #45144, a weight was not recorded for the month of June 2013 and staff present confirmed to the inspector this resident's weight should have been recorded by June 10th as per the home's policy however, it was not done. The licensee has not ensured that the programs include, 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. [s. 68. (2) (a)]

3. Inspector noted on June 26, 2013 that resident #57856 who is at moderate nutritional risk, and resident #67958 who is at high nutritional risk, did not have their weights recorded by June 10th as outlined by the home's policy. Staff interviewed indicated they were "just missed". Inspector reviewed the "Belvedere Heights Dietitian Monthly Reports" binder that indicates that on June 12, 2013, the registered dietitian documented that these residents weights were outstanding (past June 10, 2013) and needed to be taken. The licensee has not ensured that the programs include, 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. [s. 68. (2) (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 residents' weights are taken by the 10th of each month as directed by the home's policy on weights, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector observed in Mapleview dining room, resident #104 sitting at a table eating a pudding-type consistency food and drinking a beverage without a staff member present to monitor. Inspector remained in the dining room area for approximately four minutes and then proceeded down the corridor to locate a staff member. A PSW was observed coming out of a resident room and was interviewed by the inspector as to resident monitoring on the unit during meals. The worker stated to the inspector that they were the only PSW currently on the unit. Inspector informed the staff member that a resident was observed eating and drinking in the dining room unsupervised by staff. The care plan document for resident #104 indicates there is a swallowing risk and extensive assistance and encouragement is required during meals. The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: monitoring of all residents during meals. [s. 73. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents on Mapleview unit, specifically resident #104, is monitored during meals, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. Inspectors noted during the inspection that there were several rooms on the third floor with lingering offensive odours. The inspector, along with a supervisory staff person walked about the third floor. The staff member confirmed that the home had not adequately implemented its' procedures to address the lingering odours present on the unit. The licensee has not ensured that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that procedures are developed and implemented for, addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

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 as part of the organized program of housekeeping, procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (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:
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. O. Reg. 79/10, s. 110 (2).

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

Findings/Faits saillants :

1. Inspector interviewed two staff members in regards to the use of a restraint for resident #98428. Both staff confirmed that there is a requirement to monitor resident #98428 on an hourly basis and to document that those checks are performed. Two staff reported to the inspector that due to workload issues, they do not consistently monitor resident #98428 while in the restraint.
Inspector reviewed the home's policy on restraints and confirmed that the policy directs staff to monitor the resident at least every hour and to document these checks on a flow sheet specifically designed for restraint monitoring. The licensee has not ensured that resident #98428 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. [s. 110. (2) 3.]

2. Inspector audited 5 resident's records identified to have restraint devices applied on a daily basis during the time period of June 1-25, 2013. Specifically, inspector audited documentation related to the application of the restraint, hourly checks of the resident while in the restraint, removal of the restraint, resident reaction to the restraint and re-positioning or removal of the restraint every 2 hours. In 5 of 5 records reviewed, inspector noted that there were whole shifts where no documentation appeared; on average, 16.8 of 75 shifts had no documentation recorded. In addition, 5 of the 5 records failed to document the resident's response to the restraint. In addition, the inspector noted that staff were using the code "7" on the same document. This code was not found in the form's legend or the home's policy. The licensee of the home has not ensured that all assessments, reassessments and monitoring pertaining to a restraint applied on a resident, including the resident's response is documented. [s. 110. (7) 6.]

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 is restrained by a physical device under section 31 of the Act, the resident, specifically resident #98428, 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, and all assessments, reassessments and monitoring pertaining to the restraint, including the resident's response is documented, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector observed in Oak unit tub room that there were 3 prescription shampoos on the window ledge. On a subsequent day, the inspector observed that these same prescription shampoos remained in the same spot. Inspector reviewed the resident's health care records pertaining to these prescription shampoos and interviewed the Charge Nurse. Both these sources confirmed that the prescription shampoos were ordered by the resident's physician and are considered as treatments for which the registered staff are to have control of. The licensee did not ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug related supplies. [s. 129. (1) (a)]

2. Inspector noted a prescription topical ointment was on the counter top in a resident's bathroom. The inspector interviewed a PSW who stated that the prescription ointment had been in the resident's room for 2 days and acknowledged that prescription medications are to be kept in the medication cart or medication room. The licensee did not ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug related supplies. [s. 129. (1) (a)]

3. Inspector observed prescription shampoos in the Pinecrest tub room. Inspector conducted an interview with a PSW who reported that the prescription shampoos are stored in the tub room as part of normal practice so that they may be used when a resident has their bath. The licensee failed to ensure that, drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies. [s. 129. (1) (a)]

4. Inspector interviewed an RPN about the storage of controlled substances, specifically Ativan/Lorazepam. The staff member reported to the inspector that if a resident is on this medication it is kept in the medication roll and not stored separately in the locked box of the medication cart. The licensee has not ensured that 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. [s. 129. (1) (b)]

5. Inspector reviewed resident #888's Medication Administration Record (MAR) and noted that on a daily basis, the resident is to receive a controlled substance, specfically Ativan/Lorazepam. Inspector observed that this drug is provided in the resident's packet pouch for the 0800h medication pass located in the resident's bin compartment in the medication cart. In an interview with the inspector, an RPN

confirmed the resident's #888 Ativan was not locked in the double locked compartment. The licensee has not ensured that 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. [s. 129. (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 drugs are stored in an area or a medication cart that is used exclusively for drugs and drug related supplies and that 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, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. Inspector observed hair combs in a drawer, in the tub room on Pinecrest unit. Inspector interviewed a PSW on Pinecrest unit regarding the hair combs found. It was reported to the inspector that the 3 unlabelled combs in the drawer, were "communal combs", used for any residents that may need them. All 3 combs had numerous hair fragments on the tines. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

2. Inspector noted in the tub room on Oak unit that a "rub-on" deodorant was sitting on the counter top. The deodorant did not have a label on it to identify which resident it belonged to. Inspector spoke to a PSW on the unit who confirmed that the deodorant was a "community" deodorant and that she had witnessed staff using this deodorant on several different residents. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

3. Inspector reviewed the health care records of 10 newly admitted residents this year and noted the following regarding tuberculosis screening:
* 5 of 10 residents were not screened for tuberculosis within 14 days of admission (these residents screened 76,25,17,35, and 21 days post admission)
The licensee has not ensured that residents admitted to the home are screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. [s. 229. (10) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program with regards to personal care items, including combs and deodorant, and that residents admitted to the home are screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector walked into the shower room, #81A on Pinecrest unit and observed brown tinged fluid leaking from the ceiling and collecting onto the base of the Prelude walk-in shower. Staff interviewed on the unit by the inspector were not aware that the shower room was leaking from the ceiling. The licensee has not ensured that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (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); 2007, c. 8, s. 85. (4).
(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; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(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 inspector interviewed a representative of the Family Council and reviewed Family Council meeting minutes. The inspector was unable to identify that the results of the satisfaction survey were made available to the Family Council. Inspector interviewed a supervisor within the home who was unable to verify that the results of the satisfaction survey were made available to the Family Council. The licensee has not ensured that, the results of the satisfaction survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); [s. 85. (4) (a)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
1. The resident's ability under subsection 82 (2) of this Regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1). O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. Inspector reviewed the package of information given to residents and families upon admission. The inspector was unable to locate any reference regarding the ability of the resident to retain a physician or registered nurse in the extended class (EC) to perform services required under subsection 82(1). Inspector reviewed the admission package with a supervisory staff member who confirmed that there is no reference to the resident's ability to retain a physician or registered nurse (EC) to perform the services required under 82 (1). The licensee has not ensured that the package of information provided for in section 78 of the Act includes information about the following: the resident's ability under subsection 82(2) of this Regulation to retain a physician or registered nurse (EC) to perform the services required under subsection 82(1). [s. 224. (1) 1.]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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:

COMPLIED 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. 44. (9)	CO #001	2011_050151_0024	163
O.Reg 79/10 s. 49. (2)	CO #001	2013_139163_0015	163

Issued on this 26th day of July, 2013

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

Diana Stenlund, #163