Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 9, 2015	2015_287548_0011	O-001969-15	Resident Quality Inspection

Licensee/Titulaire de permis

BROADVIEW NURSING CENTRE LIMITED
210 Brockville Street Smiths Falls ON K7A 3Z4

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

BROADVIEW NURSING CENTRE
210 Brockville Street Smiths Falls ON K7A 3Z4

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

RUZICA SUBOTIC-HOWELL (548), ANANDRAJ NATARAJAN (573), RENA BOWEN (549)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 19,20,21,22,25,26,27,28,29, 2015.

As part of the inspection two Critical Incident Reports were inspected on. They are:Logs #: O-001348-14 and Log#:O-000504-14.

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, President of the Residents' Council, the Administrator, Director of Care (DOC), Quality Improvement Coordinator (QIC), Maintenance Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Workers, (PSW), Activity Director, Physiotherapy Assistant and Activity Aide.

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
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

11 WN(s)
7 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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. The Licensee failed to ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

On May 20, 2015 inspector #549 observed that the privacy curtain does not close completely at the window side of the bed for rooms 119-2, 125-3 and 127-1. Likewise, inspector #573 observed that the privacy curtain does not close completely at the window side of the bed for rooms 111-1 and 113-4.

On May 21, 2015 inspector #573 observed that the privacy curtain does not close completely at the window side of the bed for room 112-2.

On May 25, 2015 inspector #548 observed rooms 111, 112, 125 and 127. It is noted that these rooms are four bedroom ward rooms equipped with one continuous track on the ceiling above each resident bed. The inspector observed that when the two privacy curtains are pulled completely they do not meet, resulting in a one foot gap between bed 111-1 and 111-2, and 111-3 and 111-4. The same was observed in room 125 for beds 125-3 and 125-4. As well, for beds 111-2 and 111-3 the privacy curtain ends at the edge of the resident's foot board with a gap of approximately two feet, on the window side of the bed. The same was observed in room 112 for beds 112-2 and 112-3.

It was observed in room 117-1 that when the privacy curtain is completely drawn there is a gap of approximately 6 feet and the resident bed can be seen upon entering the room.

On May 26, 2015 the Maintenance Manager indicated that the track affixed to the ceiling is used for a ceiling lift in these rooms. The Maintenance Manager and the inspector observed the one foot gap between the two privacy curtains in rooms 111 and 112.

The Maintenance manager indicated that there is a track affixed in the ceiling for a privacy curtain for bed 111-3 however it was not installed after cleaning. He indicated there are clips that hold the two privacy curtains together when the curtains are pulled completely in order to provide privacy between resident beds. The Maintenance manager observed that there were no clips on these privacy curtains.

It was noted for the resident beds listed above there were no clips on the privacy curtains, there was one track installed with no privacy curtain and no track installed for a privacy curtain for the other beds. As such, the licensee failed to provide privacy for residents. [s. 13.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that that the home, furnishing and equipment are kept clean and sanitary.

During an interview with Inspector #549 on May 26, 2015 the Quality Improvement Coordinator (QIC) indicated that the PSWs are responsible for the weekly cleaning of the resident's mobility equipment. The Resident Equipment Cleaning Schedule indicates what day is assigned for the weekly cleaning of the individual resident's mobility equipment.

The QIC indicated that the home's process for cleaning the resident's mobility equipment is that the PSWs will follow the Resident Equipment Cleaning Schedule, clean the equipment on the weekly assigned day then sign off that the task has been completed in the POC.

The QIC also indicated to Inspector #549 that the home's expectation is that the PSWs will wipe the resident's mobility equipment as required in-between each thorough weekly cleaning.

On May 19, 2015 Inspector #549 observed that the wheelchair used by Resident #1 had what appeared to be dried food debris on both sides of the wheelchair by the brake handles and the front wheels. Resident # 1's wheelchair is scheduled to be cleaned every Friday evening shift as indicated on the Resident Equipment Cleaning Schedule. The POC documentation indicated that the resident's wheelchair was cleaned on May 20, 2015. Dried food debris was noted on both sides of the Resident #1 wheelchair and by the brake handles and front of wheels by Inspector #549 on May 22 and May 26, 2015.

On May 20, 2015 Inspector #573 observed that the wheelchair used by Resident #7 was unclean around the frame and the seat belt which is tied under the seat had visible dust and debris on it. Resident # 7's wheelchair is scheduled to be cleaned every Thursday evening shift as indicated on the Resident Equipment Cleaning Schedule. The POC documentation indicated that the resident's wheelchair was cleaned on May 21, 2015. On May 26, 2015 Inspector #549 observed that the wheelchair frame under the seat had a heavy accumulation of dust and dirt. The seat belt which is clipped under the chair as it is not in use at the present time had dried debris and thick visible dust on it. The calf protector also had dried debris on it during the same observation on May 26, 2015.

On May 21, 2015 Inspector #573 observed that the wheelchair used by Resident #9 had stains and debris near the brakes and the small front wheels. Resident # 9's wheelchair is scheduled to be cleaned every Wednesday night shift as indicated on the Resident Equipment Cleaning Schedule. The POC documentation indicated that the resident's wheelchair was cleaned on May 21, 2015. On May 26, 2015 Inspector #549 observed that the resident's wheelchair had what appeared to be dried food debris along both sides of the frame by the brakes and on the small front wheels.

On May 21, 2015 Inspector #549 observed that the walker used by Resident # 18 had white stains on the seat of the walker and on the outside of the carrying case attached to the walker. On May 22, 2015 at 3:00pm it was noted by Inspector #549 that the resident's walker had the same white stains on the seat and on the outside of the carrying case attached to the walker as observed earlier in the day. Resident # 18's walker is scheduled to be cleaned every Friday day shift as indicated on the Resident Equipment Cleaning Schedule. The POC documentation indicated that Resident #18’s

walker was cleaned on May 22, 2015. On May 26, 2015 Inspector #549 observed the same white stains on the seat of the walker and on the carrying case attached to the walker.

On May 27, 2015 the QIC accompanied Inspector #549 to inspect Resident #1, 7, 9 and 18's mobility equipment for cleanliness. The QIC confirmed that Resident #1, 7, 9 and 18's mobility equipment was unclean and that the debris and stains appeared to be dried on. It was also observed by Inspector #549 and the QIC that the dust on each piece of mobility equipment was thick. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment are maintained and in a good state of repair.

The Resident's rooms are equipped with a washroom which is either shared or private depending on the resident's accommodation.

On May 27, 2015 Inspector #549 observed the following:

Room # 118 the left side of the door frame entering the resident's washroom was missing the corner protector guard. The area where the corner vinyl protector guard was missing was covered with dried discolored glue.

Room # 120 both sides of the door frame entering the resident's washroom was missing the corner vinyl protector guard. The area where the corner vinyl protector guard was missing was observed to be covered with dried discolored glue.

Room # 122 the corner vinyl protector guard was lifting from the washroom door frame on the left and right side from the bottom up about 4 inches on both sides.

Room # 123 the corner vinyl protector guard was missing on both sides exposing the metal door frame in several spots.

Room # 124 the vinyl protector guard was missing from both sides of the washroom door frame. The area where the corner vinyl protector guard was missing was observed to be covered with dried discolored glue. As well , for room 125.

During the same observation Inspector #549 also noted that in Room # 102,103,109, 110 121,122,123,and 124 that the brown corner flexible baseboard at the entrance to the

room beside the washroom door frame was missing exposing the unfinished gyprock which was covered in dried discolored glue.

On May 27, 2015 the Maintenance Manager indicated that the vinyl corner protector guards and the corner flexible baseboards have been purchased and will be installed. The Maintenance Manager was not able to provide Inspector #549 with a time frame for the installation of the vinyl corner protector guards or the flexible corner baseboards.

On May 28, 2015 the Administrator confirmed with Inspector #549 that she is aware of the missing vinyl corner protector guards and the missing flexible corner baseboards in the above noted resident rooms. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that that the homes furnishing and equipment are kept clean and sanitary and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to respond to Resident's Council in writing within 10 days of receiving advisement from council.

On May 22,2015 during an interview the President of Resident's Council indicated that issues and concerns are raised at meetings and she is aware that the home must respond to council within 10 of receiving their advisement.

Upon record review of council meeting minutes it was noted that on March 12, 2015 several concerns were raised: Nursing, Laundry, Food services and Noise level. The Administrator responded to council in writing on March 24, 2015.

Resident Council met on July 10, 2014 and advised the home of their concerns regarding Laundry, Nursing, Pest control and Lack of supplies. The Administrator responded to council in writing on July 25, 2014.

On May 22, 2015 the Activity Director indicated that both he and council secretary take meeting minutes and he provides them to the Administrator who responds to council in writing within 10 days.

On May 25, 2015 Inspector #548 spoke with the home's Administrator who indicated that she is aware a written response to council is to be completed within 10 days and indicated she had not noted the dates of these two meetings when she had responded to them.

Concerns related to the operation of the home were brought forward to the licensee, as represented by the home's Administrator. As such, more than 10 days passed without the provision of a written response. [s. 57. (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 respond in writing to Resident's concerns related to the operation of the home within 10 days of receiving advisement from council, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to convene semi-annual meetings to advise such persons: residents', families and persons of importance to residents, of the right to establish a Family Council.

On May 19, 2015 during the entrance conference the Administrator indicated that there was no Family Council at the home.

On May 25, 2015 during an interview the Administrator indicated that there has been no family council for about 5 years. The Administrator indicated that during new resident admissions she provides information to the resident and /or family member of the right to establish Family Council.

The Resident Admissions Package provided no information regarding the right to establish Family Council. The Administrator confirmed that the admissions package does not mention this information. The Administrator indicated that she was unable to provide any documentation of discussions with residents and/or family members regarding Family Council to the inspector #548.

The Administrator confirmed that the Licensee does not convene semi-annual meetings to advise Residents', families or persons of importance of the right to establish a Family Council. [s. 59. (7) (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 it convenes meetings on a semi-annual basis to advise residents', families and persons of importance of the right to establish a Family Council, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all foods and fluids are prepared, stored, and served to preserve taste, nutritive value, appearance and food quality.

During observations of the lunch meal service on May 19, 2015, inspector #573 observed S#115 placing spilled whipping cream from a servery tray over a (Jell-O) dessert. The inspector observed that the staff member did not discard or clear the dessert from the servery tray. It was also observed by the inspector that the other staff members are serving desserts from the same servery tray. Immediately Inspector went and spoke to PSW S#115 who indicated that the dessert was to be served for Resident #23 and the staff acknowledged that she placed the whipping cream from the servery tray over the dessert. After inspector spoke with the staff member, she went to the kitchen to get a new dessert for the Resident #23.

The PSW S#115 failed to use serving methods that would preserve taste, nutritive value, appearance and food quality for Resident #23. [s. 72. (3) (a)](573) [s. 72. (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 all food and fluids are prepared, stored and served to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that that procedures are developed and implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks.

The resident washrooms shared and private are equipped with console sinks that are designed to have two metal support legs extending down from under the front of the sink to the floor.

On May 27, 2015 Inspector #549 observed the following in the resident washrooms:

Room #104,114,117,126 the console sink was missing the right metal support leg.
Room #106 the console sink was missing the left metal support leg
Room #111 the console sink was missing both metal support legs.
Room #116 the console sink had a loose left metal support leg.
Room #121 the console sink was missing both of the metal support legs, one of the support legs was leaning up against the wall in the corner of the bathroom.

Room #125 the console sink had a bent left support leg.

On May 27, 2015 during an interview with the Maintenance Manager it was confirmed with Inspector #549 that the support legs for the resident washroom console sinks were missing in Room # 104, 106, 111, 114, 116, 117, 121, 125 and 126.

The Maintenance Manager indicated during the same interview that the console sinks have a wall bracket at the back of the sink for the sink to sit on for some stability; however he did confirm that the console sinks are intended to have the two metal support legs attached at the front under side of the sink reaching to the floor.The Maintenance Manager also indicated that there is the possibility that the caulking around some of the console sinks may be pulling from the wall due to the missing metal support legs.

On May 27, 2015 Inspector #549 also observed the caulking around the following sinks to be either missing or has pulled away from the wall allowing water and debris to enter the wall surface: Room #104, 111, 116, 117, 121, 124, 125, 126 and 127.

It was indicated by the Maintenance Manager to Inspector #549 that the metal support legs are being replaced but he had some difficultly purchasing them due to the age and style of the sinks.

The Maintenance Manager confirmed that the replacement of the metal support legs and replacement of the caulking around the resident washroom console sinks are included as part of the home's maintenance program.

The Maintenance Manager was not able to provide Inspector #549 with a time frame when installation of the metal support legs for the console sinks or the caulking around the sinks would be completed.

On May 28, 2015 the Administrator confirmed with Inspector #549 that she is aware that several of the console sinks in the resident washrooms are missing the metal support legs. [s. 90. (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 procedures are developed and implemented for the maintenance of plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories, to be implemented voluntarily.

WN #7: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participate in the implementation of the Hand hygiene program.

The Home's infection prevention and control program policy IFC B-15 dated April 17, 2014 includes detailed Hand hygiene program for all staffs in the Routine Practices. Under Hand hygiene in bullet 1, 7 and 9 it clearly indicates "Hands should be washed:

- Immediately and thoroughly before and after providing care for the resident and after contact with
  contaminated objects
- Before preparing, handling, serving or eating food and before feeding a residents
- Whenever hands appear soiled"

On May 19, 2015 during the lunch meal service inspector #573 observed PSW S#115 removing residents dirty dishes from the table, clearing the remaining food in the garbage bin and placing the dirty dishes in a clearing tray. After placing the dirty dishes in a clearing tray it was observed that the staff member was rubbing her fingers in the clearing tray and returned to serve hot beverages to residents at table 15, then she proceeded to assist 2 residents requiring feeding assistance at table 12. The staff

member continued feeding the two residents at table 12 which included the staff member handing sandwiches with her fingers to Resident #23. At no time hand washing/hygiene was observed.

On May 20, 2015 inspector #573 observed PSW S#115 clearing dirty dishes from resident tables, rubbing her hands together and proceeded to open the kitchen door with both hands, obtained a dessert and its cutlery from a servery cart. It was observed by the inspector that the staff member was not holding the cutlery from the handle of the spoon to serve the dessert to a resident and then she went to assist handing sandwiches with her fingers to Resident #24 at table 2. At no time hand washing/hygiene was observed.

During the same lunch service, inspector #573 observed a second PSW S#117 clearing dirty dishes from several resident tables then went to obtain two desserts and its cutlery from the servery cart. It was observed that the PSW S#117 was not handling the dessert spoons from the handle and the staff member served those desserts to the residents and then proceeded to assist a resident with feeding at table 9. At no time hand washing/hygiene was observed.

Inspector #573 observed AHR (Alcohol based Hand Rubs) hand hygiene agents and dispensers placed in the carts and also in the dining room walls.

During the meal service not all staff members were observed to follow or participate in the home's infection prevention and control program, specifically with the hand hygiene and hand washing. [s. 229. (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 all staff participate in the implementation of the home's Hand Hygiene program, to be implemented voluntarily.

WN #8: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for Resident #05 in relation to Behaviours was not provided to the resident as specified in the plan.

Inspector #573 reviewed Resident #05's plan of care for Personal Hygiene, Dressing, Toileting and Behaviours in effect dated April 14, 2015 it states "Provide 2 staff for all care related to behaviours".

During an interview Resident #05 indicated that care is provided by one staff member.

On May 25, 2015 inspector #573 reviewed Resident #05's Point of care (POC) documentation for Personal Hygiene, Dressing and Toileting from April 1, 2015 to May 25, 2015. The POC documentation indicates that Resident #05 was provided care by only one staff member.

Inspector #573 interviewed PSW S#101, PSW S#115 and PSW S#117 all indicated that Resident #05 care related to Personal Hygiene, Dressing, and Toileting is usually provided by one staff member.

On May 25, 2015 the Homes Quality Improvement Coordinator (QIC), stated that due to Resident #05 existing responsive behaviours with the staff members related to the resident's medical condition it is the home's expectation that there should be always be two staff members with the resident when care is provided. QIC also indicated that the resident is verbally abusive towards staff and the resident had made several false accusations about staff in the past.

Resident #05's plan of care indicated that two staff members are required for all care as it relates to behaviours, was not provided to the resident as specified in the plan. [s. 6. (7)]

2. During observations of the lunch meal service on May 25 and 26, 2015, Inspector #573 observed RPN S#110 assisting Resident #08 with fluids. Resident #08 was seated in a tilted position (approximately 130 degrees to 140 degrees) in a tilt wheelchair.

Resident #08 plan of care for Dietary dated March 24, 2015 identified that the resident having difficulties with swallowing. Furthermore, the plan of care indicated that the resident requires extensive assistance with feeding with one staff and for staff to ensure that the resident is always sitting at a 90 degree angle for all meals.

On May 26, 2015 inspector #573 spoke with RPN S#110 regarding the positioning of the resident. RPN S#110 stated that usually the resident is seated in tilted position during meals for comfort. When inspector indicated to the RPN S#110 regarding the safe feeding positioning instructions for Resident #08 as per the plan of care, the staff immediately repositioned the resident wheelchair in to upright position (90 Degrees) and continued with the meal.

On May 26, 2015 inspector #573 spoke with Director of Care (DOC), indicated that Resident #08 care needs, as per the care plan, indicated that the Resident #08 be positioned at a 90 degrees angle in the wheelchair during all meals.

Staff member #110 did not provide the care set out in the plan of care for Resident #08. [s. 6. (7)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(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. The licensee has failed to ensure that the resident-staff communication and response system is available in every area accessible by residents.

On May 19, 2015 inspector #573 observed that there was no resident-staff communication and response system available on the residents sitting area located in close proximity to the nursing station.

On May 28, 2015 during an interview all three staff members RPN S#113, RPN S #120 and RN S#121 indicated that the area in front of the nursing station is an official resident area accessible to all residents on the units. Further the RN S#121 indicated that residents and families will gather in this sitting area for socials to chat with the residents.

On May 28, 2015 The Administrator confirmed to Inspector #573 that there is no resident-staff communication and response system in the residents sitting area near the nursing station and further indicated that the closest location of audio/visual resident-staff communication and response system is in the activity room next to the Resident sitting area. The Administrator also stated to inspector #573 that she will discuss with the home's system provider the process for installing a resident-staff communication and response system in the residents sitting area. [s. 17. (1) (e)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements.

On May 19, 2015 inspector #573 noted that not all of the required information was posted in the home.

The LTCH Licensee Confirmation Checklist-Admission Process was completed by the Quality Improvement Coordinator on May 19, 2015. The following section on the LTCH Licensee Confirmation Checklist-Admission Process related to the posting of required information was marked with a "yes" as being posted: The most recent minutes of the Resident's Council. [s.79. (3) (n)].

On May 28, 2015 the Administrator and inspector #548 toured the home and it was confirmed by the Administrator that the required information listed below was not posted:

1. Notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained [s.79. (3) (g)];
2. The name and telephone number of the licensee [s.79. (3) (h)];
3. The most recent minutes of the Resident's Council meetings, with consent of the Resident's Council. [s.79. (3) (n)]and;
4. An explanation of the protections afforded under section 26 (Whistle-blowing protection). [s.79.(3)(p)] [s. 79. (3)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are destroyed by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10,s. 136 (3)(b) (i)(ii)

On May 26, 2015 RN #111 indicated to Inspector #549 that the discontinued/expired non-controlled drugs which are to be destroyed are put in a large white plastic disposal container in the medication storage room by registered staff acting alone.

During the same discussion RN #111 indicated that the non-controlled drugs in the white disposal container are not altered or denatured to such an extent that its consumption is rendered impossible or improbable before the white disposal container is removed from the home by SteriCycle for disposal as required under O.Reg 79/10,s 136(6) .

The QIC and DOC confirmed with Inspector #549 on May 26, 2015 that the controlled drugs are destroyed by the QIC and the Pharmacist acting together however the non-controlled drugs are destroyed by a registered staff member acting alone. The QIC and DOC also confirmed that the non-controlled drugs are not denatured or altered to such an extent that its consumption is rendered impossible or improbable. [s. 136. (3) (b)]

Issued on this 25th day of June, 2015

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

Original report signed by the inspector.