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
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 6, 7, 8, 9, Aug 5, Sep 7, 9, 19, 20, 2011	2011_056158_0003	Critical Incident

Licensee/Titulaire de permis

EXTENDICARE NORTHWESTERN ONTARIO INC
333 York Street, SUDBURY, ON, P3E-4S4

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

EXTENDICARE FALCONBRIDGE
281 FALCONBRIDGE ROAD, SUDBURY, ON, P3A-5K4

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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), RAI co-ordinator, Physiotherapy Aide, Personal Support Workers (PSW), Food Service Worker, Dietitian

During the course of the inspection, the inspector(s) reviewed the health care records of residents, the internal incident reports, the critical incident reports sent to the Ministry of Health, policies and procedures related to head injury routines, and fall prevention, medical directives, restraint policy, 24-hr unit report and observed staff providing resident care.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Nutrition and Hydration

Prevention of Abuse, Neglect and Retaliation

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

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

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

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

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

Findings/Faits saillants :

1. The licensee has failed to comply with s.6(1)(c), s.6(7), s.6(8), and s.6(10)(b) in that it failed to provide clear direction to staff; to provide the care set out in the plan of care; to keep staff and others who provide direct care to the residents aware of the contents of the plan of care and failed to ensure the plan of care is revised when the resident's care needs change.
2. A resident's health care record was reviewed by the inspector on June 7/11. The resident had a fall and was transferred to hospital with an injury. The RPN progress notes identified the specific monitoring direction from the hospital emergency. The resident's plan of care did not contain this direction. This direction to staff and others providing care to this resident was not set out in the resident's plan of care.[s.6(1)(c)]
3. A resident's health care record was reviewed by the inspector on June 7/11. The resident had fall and was transferred to hospital with an injury. The resident returned to the home the next day. The resident's progress notes identified that close monitoring was required. A significant change assessment for this resident was not found. The RAI co-ordinator confirmed on June 7/11 that this assessment was not completed.
The resident's progress notes identified the use of two side rails as needed. A PSW confirmed on June 7/11 that the resident would not be able to get out of bed voluntarily. A restraint assessment or a pre-restraint assessment was not found. The resident's plan of care was not revised when the resident's care needs had changed. [s.6(10)(b)]
4. The inspector observed a resident to be eating lunch in the resident's room without supervision on June 8/11. The resident's plan of care identified that the resident is to eat in the dining room where the resident can be monitored, however the resident was eating in the resident's room without supervision. The care set out in the plan of care was not provided to the resident. [s.6(7)]

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 ensuring that clear direction is provided to staff and others who provide direct care to residents; that residents are provided with the care set out in their plan of care; that staff and others who provide direct care are kept aware of the contents of the plan of care and that the plan of care is reviewed and revised when a resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following subsections:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with s. 8 (3) ensuring that at least one Registered nurse be on duty and present in the home at all times.
The Registered Nurse staffing schedule from May 2 - May 29/11 was reviewed by the inspector on June 7/11. A Registered Nurse was not on duty or present in the home at all times on May 6/11, May 11/11, May 14/11, May 15/11, May 20/11, May 21/11 and May 29/11. This was confirmed by the Assistant Director of Care on June 8/11 and the Director of Care on June 9/11.

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 ensuring that at least one Registered Nurse is who is both an employee of the home and a regular staff member of the home is on duty and present in the home at all times, 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. The licensee has failed to comply with s. 49 (2) ensuring 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.
A resident's health care record was reviewed by the inspector on June 7/11. The resident had a fall and was transferred to hospital with an injury. The resident returned to the home with direction from the hospital emergency to closely monitor the resident for a month.
The vital sign assessments were completed for six days. Only 1 notation by the RPN was found regarding the neurological status. There is notation by the RPN in the progress notes that the home's head injury routine was discontinued after five days.
There was no significant change assessment for this resident found. A quarterly assessment was found twenty-eight days after the fall.
A fall assessment was found initiated twenty-eight days after the fall, however, it was not completed.
2. A resident's health care record was reviewed by the inspector on June 1/11. The health care record identified that the resident had a fall a month for four consecutive months. The home's head injury policy # 08-09-01 vital signs and neuro signs identified the following procedure "q15min x1, then if stable, q30min x1, q4h, q shift x72 hrs".
Assessments of the resident's vital signs and neurological reflexes for the falls were not documented as per the home's policy.

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 ensuring that a post fall assessment is completed for all residents who have fallen and have been assessed as requiring further assessment, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.
Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee has failed to comply with s.29(1)(b) in that the licensee did not ensure that the home's restraint policy was complied with.
The home's restraint policy - April 2010 was reviewed by the inspector on June 9/11. The policy identified that once a resident is assessed as requiring a restraint, a physician's order which specifies the type, usage and duration of the restraint be obtained.
The inspector observed on June 9/11 that two side rails were in the up position when a resident was in bed. The assigned PSW confirmed that the resident would not be able to voluntarily get out of bed. The resident's health care record was reviewed by the inspector on June 9/11. An assessment of restraint was completed, however, it did not identify which restraint to use or when it is to be used. A physician's order for the bed rails as a restraint was not found.
The home did not ensure that its restraint policy was complied with.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee has failed to comply with s.117 (b) ensuring that no medical directive for the administration of a drug be used unless it is individualized to the resident's need.
The home's Medical Directives policy was reviewed by the inspector on June 8/11. The policy indicates that the Registered Nurse will select the drug depending on the resident's condition and administer the medication to the resident. The medication is then transcribed on the " Physician's Order " sheet. The physician is then expected to sign the directive on his next visit.
A resident's health care record was reviewed on June 8/11 by the inspector. The medical directive for constipation is the following: give glycerine suppository if resident has no BM x 4 days.
The resident's progress notes identified "no bm x 4days, suppository given with results".
There was no order or medical directive written for this suppository administration found on the resident's physician's order sheet.
The medical directive was not used nor was it individualized to this resident's condition or need.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care
Specifically failed to comply with the following subsections:

s. 50. (1) The skin and wound care program must, at a minimum, provide for the following:
1. The provision of routine skin care to maintain skin integrity and prevent wounds.
2. Strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents.
3. Strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids.
4. Treatments and interventions, including physiotherapy and nutrition care. O. Reg. 79/10, s. 50 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with s.50(1) 3 in that the licensee failed to ensure that strategies to reduce and prevent skin breakdown and reduce and relieve pressure were provided to residents. The transfer slings were observed by the inspector to remain under five residents while they sat in their wheel chairs from 16:45 to 18:00 on June 6/11. The residents' plans of care were reviewed by the inspector. The residents' plans of care did not provide direction to keep the transfer slings under the resident when seated in their wheel chairs.
Three of the five residents were identified as having a high risk for impaired skin breakdown.

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 ensuring that residents at risk of altered skin integrity are provided with strategies that reduce and prevent skin breakdown and reduce and relieve pressure, 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 subsections:

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 has failed to comply with s.229 (4) to ensure that all staff participate in the implementation of infection control practices.
The inspector observed a PSW on one of the floors dragging a bag containing wet/soiled linen across the floor leaving a wet streak along the floor on June 8/11 at 1345.

WN #8: 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. The licensee has failed to comply with s.73(1) 9 in that the licensee failed to provide residents any personal assistance or encouragement to safely eat or drink as comfortably or independently as possible. One of the home's units morning nourishment pass was observed by the inspector on June 8/11 from the beginning to the end. It was observed that one PSW delivered the fluids to residents' rooms and left the red juice on the resident's bedside table. Assistance was not provided to any of the five residents who were in their rooms. Two of the five residents' plan of care identified that they both required total assistance with eating and drinking.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to comply with s.98 in that the licensee failed to ensure that the appropriate police force was immediately notified of two witnessed incidents of resident to resident abuse.
An incident of physical abuse between two residents which resulted in injury to one resident was not reported to the police until directed by the Ministry of Health and Long term care (MOHLTC) duty inspector.
A second physical abuse incident between two residents whereby one resident sustained injury was not reported to the police.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following subsections:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with s.104(1) 1 related to the reporting requirements of an incident of physical abuse between two residents.
The DOC identified during the June 8/11 interview with the inspector specific details during the altercation. This information was not included in the description of the event on the Critical Incident Report.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following subsections:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to comply with s.71(4) in that the licensee failed to ensure that the planned menu items were available at each meal and snack.
There are two dining areas with different sitting/meal times on each floor. On June 08/11, the inspector observed the Food Service Worker on one floor serving the noon meal to the residents who eat at the first sitting. The inspector observed the Food Service Worker call the kitchen at 1315 identifying that the Food Service Worker ran out of the regular coleslaw and that there were three servings of the vegetable medley left. The Food Service Worker identified that there were three plates left to serve on the east side before going to serve the 14 residents who eat on the west side at the second sitting. Neither the coleslaw or the alternative, the vegetable medley was available.
2. The inspector was present on an unit on June 06/11. The dining service was nearing completion at 1350. The inspector observed that one resident's request for minced hamburg was not provided. The Food Service Worker identified to the inspector that the Food Service Worker had run out of the minced hamburg. The inspector observed that the Food Service Worker made no attempt to determine whether the kitchen had extra minced hamburg. The Food Service Worker stated to the inspector that two other residents were given minced chicken sandwiches as their request for minced hamburg was not available.

WN #12: 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 licensee has failed to comply with s.24(1) in that the licensee failed to immediately report to the director, the resident to resident abuse that resulted in harm.
The incident of physical abuse between two residents which resulted in injury to one resident was not immediately reported to the Director.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to comply with s.5 in that the licensee did not ensure that the home's environment is safe for its residents. The inspector observed that a resident's room was completely dark with limited visibility at 0830 on June 8/11. A PSW working on the unit identified that the light bulb in this room needed replacing. The PSW stated this was documented two days previous in the maintenance record book. The resident's plan of care was reviewed by the inspector on June 8/11. The plan of care identified that the resident is at risk for falls and that one of the interventions for fall prevention is to ensure glare free lightening. The plan of care also identified the resident ambulates with supervision and has limited vision. The home did not ensure that the resident's environment was safe.

WN #14: 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. The licensee has failed to comply with s.3(1) 4 and 8 related to resident rights.
On June 6/11 at 1445, the call bell in a resident's room rang. The resident was observed by the inspector walking to the bathroom in the bedroom alone. The resident was then observed to be walking in the hallway with the resident's buttocks exposed. The RPN approached the resident and brought the resident to the resident's room. The resident was then observed half lying/half sitting on the bed when the RPN left to get the resident's assigned PSW. The inspector observed that a PSW went to assist the resident and accompanied the resident to the bathroom. At 1510, the inspector observed that the resident was alone in the resident's bedroom half sitting/standing by the bed with the resident's pants hanging loosely on the resident's hips. The inspector also heard the resident call out for a belt. The resident's plan of care was reviewed by the inspector and identified that the resident requires extensive assistance of one PSW for transferring and toileting. The plan of care did identify under toileting to not leave the resident unattended. The resident's right to be cared for in a manner consistent with the resident's needs was not provided. [s.3(1)4]
2. On June 6/11, the inspector observed a resident in the resident's bedroom being transferred by two PSWs at 1415. The door to the room was open and the curtain was not drawn allowing those walking by to see the resident in the resident's brief being transferred into bed with the mechanical lift.
The inspector observed two PSWs transferring another resident into bed on June 6/11 at 1545. The door was open and the privacy curtain not closed allowing the resident's bare legs to be exposed during the transfer. The resident was not wearing any clothing from the waist down at the time of the transfer.
Rights of two residents to be afforded privacy in caring for his or her personal needs were not provided. [s.3(1)8]

Issued on this 19th day of September, 2011

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