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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 13, 2014	2014_292553_0013	O-000266-14	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE KAWARTHA LAKES
125 Colborne Street East, LINDSAY, ON, K0L-2V0

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

MATTHEW STICCA (553), KELLY BURNS (554), PATRICIA BELL (571), PATRICIA POWERS (157), SAMI JAROUR (570)

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): This inspection was conducted on the following date(s): April 28,29,30 May 1,2,5,6,7 2014

A critical incident report (log #O-000129-14) was inspected concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, (Acting) Director of Care (DOC), Food Service Manager (FSM), Environmental Service Manager (ESM), Physician, Registered Dietitian (RD),Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Environmental Service Workers (ESW), Residents, Family members, and Residents' Council President.

During the course of the inspection, the inspector(s) toured the home, observed dining service, observed medication pass, reviewed resident health care records, reviewed resident council and family council meeting minutes, reviewed the homes policies on handling of medications, immunizations of staff and residents, falls prevention and management, restraints and pet visitations.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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:

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. Related to Resident #3298

The licensee failed to comply with LTCHA, 2007 c. 8, s. 6 (7), by ensuring the care set out in the plan of care is provided to the resident as specified in the plan.

Resident #3298 was assessed by a Speech Language Pathologist who made recommendations for care and the management of risk to the resident related to fluid consumption. Direction in the resident's plan of care reflected the recommendations of the Speech Language Pathologist. In an interview on May 2, the Registered Dietitian confirmed that care set out in the plan of care to manage risk to the resident related to fluid consumption was not provided as specified in the plan.

[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 to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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. LTCHA, O. Reg. 79/10 s. 136 (1) (a) requires every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction

and disposal of, (a) all expired drugs.
Review of The licensee's policy "Expiry and Dating of Medications" Policy 5-1 reviewed 01/14 directs the following:
"Procedure:
1.Examine the expiry date of all medications on a regular basis. Be especially careful to check all storage areas for extra medication, PRN medications, Government stock, monitored medication (narcotic and controlled), topicals and eye drops.
2. Remove any expired medications from stock and order replacement if necessary."

Review of the licensee's policy "Recommended Expiry Dates Once Product is Opened" Policy 5-2 reviewed 01/14 directs the following:

Product: Creams, ointments (repacked in jars)
Expiry from date Opened: 1 year.

Product: Topical mixtures (e.g. Hydrocortisone pdr in cream)
Expiry from date Opened: 6 months.

The licensee failed to comply with the home's above noted policies as evidenced by the following:

Observation of the Cameron Care Unit and Balsam Care Unit "Med Room" on May 2, 2014

Cameron Care Unit:

Resident: #3273
Prescription was filled: September 14, 2011
-The cream was repacked in a container provided by pharmacy.

Balsam Care Unit

Resident #3281
Filled: October 11, 2013.
Expiration April 2014
-The topical mixture was repacked in a container provided by pharmacy.

Resident #301

Filled October 7, 2013
Filled September 12, 2013
Expiration for both: March 2014
-The topical mixtures were repacked in a container as provided by pharmacy.

Resident: #3327
Filled: October 11, 2013
Expiration: April 2014
-The topical mixture was repacked in a container as provided by pharmacy.

Resident: #3301
Filled on December 30, 2011
Filled on February 3, 2012
Expiration: Expiration on the boxes were January, 2014
-The prescriptions listed above were found to be in their originally packaging.

Interview with Staff #201 on May 2, 2014:
When asked who is responsible for completing an audit to check for expiration of the contents of the "Med Room" on the Balsam and Cameron Care Units, Staff #201 indicated that they were unaware of any audits being completed. [s. 8. (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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place a policy for handling expired medications and is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraining of a resident by a physical device was included in the resident's plan of care.

April 29, April 30, 2014
Resident #3296 was observed wearing a lap belt with a velcro closure.
When asked to remove it by inspector on April 29 and April 30, 2014 and staff #208 on April 30, 2014, the resident was unable to do so.

Plan of care for resident #3296 dated February 25, 2014 directs the following:
- Uses velcro lapbelt, while in wheelchair, not a restraint, Resident #3296 can remove it when asked.

April 29, 2014 - Staff #208 reported that the resident wears a velrco belt to prevent them from slipping and is able to undo it on their own.
When staff #208 asked the resident to remove the belt, Resident #3296 was unable to do so.
April 30, 2014 - Resident was again observed to wearing a seatbelt - DOC(#201) advised that the resident had been reassessed and the seat belt was going to be removed when a chair alarm was available. [s. 31. (1)]

2. Related to Resident(s) #3296, 3327, and 3304

The licensee failed to comply with O. Reg. 79/10, s. 31 (2) by ensuring that the restraining of a resident by a physical device may be included in a resident's plan of care only if, 4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

Resident # 3296 was observed, by inspector #157, wearing a Velcro lap belt on April 29 and April 30, 2014; when asked to unfasten or remove lap belt, resident was unable to do so.

Staff #208 on April 30, 2014, indicated that Resident #3296 was unable to remove the lap belt without staff's assistance.

A review of the physician's orders for the period of February 01, 2014 through to May 01, 2014, concluded that there were no physician's orders for use of a physical restraint for this resident.

As of May 01, 2014, the lap belt is no longer in use for Resident #3296.

2) Staff #208 indicated during an interview on April 29th that two (2) full bed rails were being utilized for Resident #3327 and #3304; staff #208 stated that both residents were unable to voluntarily get out of bed on their own.

A review of the physician's orders for the period of January 29, 2014 through to April 30, 2014, for Resident #3304, concluded that there were no current orders for use of bed rails as a means of a restraining device. The only order on file for this resident for the use of two bed rails is dated August 13, 2013.

A review of the physician's orders for the period of January 01, 2014 through to April 30, 2014, for Resident #3327, concluded that there were no orders for use of bed rails as a means of a restraining device. The only order on file for this resident for the use of two bed rails is dated October 08, 2013.

Restraint Records reviewed for the period of January 01, through to April 30, 2014, indicated that full bed rails (2) were being applied daily for Residents #3304 and #3327, while residents were in bed. Restraint use was being monitored hourly when restraints were in place. Families of both residents had previously consented to the use of bed rails.

As of May 01, 2014, both Resident #3304 and #3327 have physician's orders for use of two bed rails while in bed, pending family approval. [s. 31. (2) 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 the restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied: A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining., to be implemented voluntarily.

WN #4: 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. The licensee failed to ensure that drugs are stored in an area that is used exclusively for drugs and drug related supplies.

On each of the care units (Balsam and Cameron) there is a room designated as the "Med Room". In each of the rooms there are personal care products such as razors, soaps and lotions. In addition to the personal care products there are treatment creams and wound care supplies that are in plain sight on top of a treatment cart. Some examples of these items are as follows:

On Balsam Care Unit "Med Room"

Examples of Treatment creams and or Wound Care Supplies
-Bactroban 2% Ointment
-Canestan ComforTABS
-Clotrimaderm Cream with Hydrocortisone 1% powder
-Ectosone 1% cream mixed with menthol/camphor 1/4%

On Cameron Care Unit "Med Room"

Examples of Treatment creams and or Wound Care Supplies:
-Tiamol Cream 0.05%

an open box of Bactigras and used container of intrasite gel are present.

Both of these rooms are accessible to Registered and Non-registered Staff by use of a key located close to the door frame of each room. [s. 129. (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 drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs within the home and the Administrator.

Each Care Unit (Balsam and Cameron) within the home contains a room called a "Med Room". These rooms store personal care supplies as well as treatment creams for Residents. The key for these rooms are located outside of each room hanging by a chain attached to the wall.

In an interview with Staff #224 on May 5, 2014 at 08:45 they indicate that housekeeping staff will enter that room on nights to clean the room. Staff #224 indicated that the "maintenance guys" will go in to the rooms on nights.

In an interview with Staff #225 on May 5, 2014 at 08:50hrs, Staff #225 indicated that the "guys" on the afternoon and night shift will go in to tidy the "Med Rooms". [s. 130. 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to ensure the security of the drug supply, including the following:
All areas where drugs are stored shall be kept locked at all times, when not in use.
Access to these areas shall be restricted to, persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. Related to Residents #0280, 0272 and 0278

The licensee failed to comply with O. Reg. 79/10, s. 131 (2) by ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

- Resident #0280 was admitted, the same day the attending physician wrote orders to administer Tetanus and Diphtheria (Td) vaccination; consent was signed by the resident or substitute decision maker on day of admission. 54 days later the vaccination had not yet been administered.

- Resident #0272 was admitted, the same day the attending physician wrote orders for

the administration of Pneumovax and Td vaccinations; the consent(s) were signed by the resident or substitute decision maker on day of admission. 89 days later the vaccinations had not yet been administered.

- Resident #0278 was admitted, the same day the attending physician wrote orders for the administration of Pneumovax and Td vaccinations; the consent(s) were signed by the resident or substitute decision maker on day of admission. 78 days later the vaccinations had not yet been administered.

The Acting Director of Care indicated no awareness that the vaccinations had not been administered to the specified residents as directed and that the immunizations are usually completed upon admission, according to the Admission Checklist.

The Acting Director of Care indicated, the above identified residents had received immunizations as ordered, while inspection was occurring. [s. 131. (2)]

2. Related to Log #O-000129-14 – Resident #0271

The licensee failed to comply with O. Reg. 79/10, s. 131 (5), by ensuring that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

The home submitted a Critical Incident Report with regards to Resident #0271.

During a review of the progress notes for Resident #0271, the following was noted to be documented by registered nursing staff:

Medication was found in Resident #0271's room. It was reported that the resident forgot to take the medication. When the resident's room was further inspected, another medication was found on the bedside table.

Resident #0271, did not have any physician's orders indicating that staff may leave medications at bedside nor orders indicating that resident may self medicate.

The Acting Director of Care (ADOC), on May 5th, indicated awareness of the charting in the progress notes regarding medications and the ADOC could not be certain if Resident #0271's room had been checked for medications.

ADOC indicated staff have been recently provided with education surrounding safe medication practices, specifically regarding not leaving medications at bedside or unattended with residents. [s. 131. (5)]

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 administered to residents in accordance with the directions for use specified by the prescriber and to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, 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. (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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. Related to Resident # 0272, 0279 and 0280

The licensee failed to comply with O. Reg. 79/10, 229 (10) 1, by ensuring that each resident admitted to the home is screened for Tuberculosis(TB) 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.

A review of the home's policy Resident TB Testing (INFE-02-01-05) directs that all residents admitted to the home must be screened for tuberculosis within 14 days of admission unless there has been screening and or testing done 90 days prior to admission.

Acting Director of Care (ADOC) indicated that the home is not yet following the new guidelines for resident > 65 years as local health unit has not yet issued this directive. ADOC indicated TB Step 2 testing remains in effect for the home.

Review of resident health care records, specific to immunization indicated:
- Resident #0272 was admitted and was not administered TB screening until 20 days later.
- Resident #0280 was admitted and was not administered TB screening until 55 days later.
- Resident #0279 was admitted and there is no documentation of admission TB screening being completed.

The Acting Director of Care indicated that Resident #0280 has been administered Step 1 of the 2 Step Mantoux Testing during inspection.

ADOC indicated that an auditing process will be initiated to ensure TB screening is being completed within 14 days of admission. [s. 229. (10) 1.]

2. The licensee failed to comply with O. 79/10, s. 229 (10) 4, by ensuring that staff are screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none in accordance with prevailing practices.

A review of the home's policy Staff Immunization Status (INFE-02-01-02) directs that all staff upon hire are to submit to their supervisor a copy of their immunization status showing the dates and results of TB test completed in the past year. Staff who have not had a TB test in the past year are required to have the test completed as a condition of hire; the test must be completed before staff begins work.

A review of employee health records indicated:
- staff #222, was hired and had no documented evidence of TB screening at time of inspection.

- staff #223, was hired and had no documented evidence of TB screening at time of inspection.

Acting Director of Care, whose duties include Infection Control Lead, indicated that TB screening had not been tracked for new hires and that new employee's hired in 2014 had not been screened for TB.

Acting Director of Care indicated that both employee's had been contacted on May 01, 2014 and request made for TB testing to be completed. [s. 229. (10) 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 1) To ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

2) To ensure that staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #8: 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. The licensee failed to comply with O. Reg. 79/10, s. 37 (1) (a), to ensure that each resident's personal items were labelled, as evidenced by the following:

Observed by Inspector #157
- Resident #3281 – a bar of soap was observed on the sink vanity, the soap was not in a labelled container; this is a shared washroom.
- Resident #3296 - a bar of soap was observed on the sink vanity, the soap was not in a labelled container; this is a shared washroom.

Observed by Inspector #554
- Resident #3304 – a bar of soap was observed sitting on the sink vanity, a second bar of soap was seen sitting on top of the paper towel holder, the soap bars were not in a labelled container; this is a shared washroom.
- Resident #3305 – a bar of soap was observed sitting on the sink vanity, the soap was not in a labelled container; this is a shared washroom.
- Resident #3327 – a bar of soap was observed sitting on the sink vanity, the soap was not in a labelled container; this is a shared washroom.

Staff #208 indicated that personal care and grooming supplies are labelled on admission and as required.

The Acting Director of Care, indicated during an interview on May 1st, that resident's care and grooming supplies were to be labelled for individual resident use. [s. 37. (1) (a)]

WN #9: 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 failed to comply with LTCHA ,2007,S.O. 2007, c.8, s 57 (2) in that the licensee did not respond in writing within 10 days of receiving a concern or

recommendation to the Residents' Council.

On May 06, 2014, inspector #570 reviewed the Residents' Council meeting minutes between January 2014 and April 2014.

The Residents' Council meeting minutes of March 10, 2014 indicated concerns about food and room temperatures.

The Dietary manager responded in writing to the Residents' Council on March 25, 2014 regarding the food concerns. The written response was not communicated to the Residents' Council within 10 days.

There is no evidence to support that a written response from the licensee regarding the room temperatures was communicated to the Residents' Council.

The Residents' Council meeting minutes of February 10, 2014 indicated concerns regarding laundry being delivered to the wrong person and water leaking on the carpet from outside.

There is no evidence to support that a written response from the licensee regarding the laundry and water leak concerns were communicated to the Residents' Council.

The Residents' Council meeting minutes of January 13, 2014 indicated concerns regarding issues brought to food committee not being addressed and Residents' rooms are not being cleaned very well.

The Dietary manager responded in writing to the Residents' Council on January 30, 2014 regarding the food committee concerns. The written response was not communicated to Residents' Council within 10 days.

There is no evidence to support that a written response from the licensee regarding the cleanliness of residents' rooms were communicated to the Residents' Council.

On May 6, 2014, the President of the Residents' Council confirmed during an interview with Inspector #570 that the Residents' Council receive written responses. The President confirmed no written responses were received in regards to the above mentioned concerns.

On May 6, 2014, the Administrator reported to Inspector #570 that written responses are provided to Residents' Council. The administrator confirmed no written responses were communicated to the Residents' Council in regards to the above mentioned concerns. [s. 57. (2)]

WN #10: 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:
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. Related to Resident #3296 and #3326

The licensee failed to comply with O. Reg. 79/10, s. 73 (1) 11, by ensuring there are appropriate furnishings and equipment in resident dining areas, specifically pertaining to tables at an appropriate height to meet the needs of all residents.

Resident #3296 was observed sitting in a wheelchair at the dining room table, during the lunch meal on April 28 and May 2nd, the edge of the table was parallel to the resident's shoulders, making it difficult for resident to reach meal plate on the table.

Resident #3326 was observed partially sitting, on a cushion, on a chair at the dining room table, during the lunch meal on April 28 and May 2nd, the edge of the table was parallel to the resident's nose; resident was having difficulty remaining in an upright posture while at the table Staff were observed assisting resident at mealtime.

Administrator indicated on May 2nd, that the home did not currently have any height adjustable tables. Administrator further indicted that Resident #3326 would be referred for seating assessment, for positioning options during mealtime.

The home is currently in the process of locating a height adjustable table. [s. 73. (1) 11.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. Related to Log # O-000129-14 – Resident #0271:

The licensee failed to comply with O. Reg. 79/10, s. 107 (1) by failing to immediately report to the Director, in as much detail as is possible in the circumstances, of the following incidents: 2. An unexpected or sudden death, including a death resulting from an accident or suicide.

As a result of an unwitnessed incident Resident #0271 was assessed by registered nursing staff and noted to be experiencing physical health concerns which required the resident's transfer to hospital for further assessment. The resident was transferred tto hospital one hour after the reported incident.

Resident #0271 was reported to have deceased while in hospital.

The Acting Director of Care reported that there was no coroner's investigation as cause of death was not related to the incident.

The home submitted a Critical Incident Report indicating Resident #0271's death was unexpected two days after occurrence.

Under O. Reg. 79/10, s. 107 (1) an unexpected death requires an immediate report to the Director. [s. 107. (1)]

Issued on this 14th day of May, 2014

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

MATTHEW STICCA #553