Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Jul 17, 2014	2014_202165_0018	L-000679-14	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF BRUCE
671 Frank Street, WIARTON, ON, N0H-2T0

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

GATEWAY HAVEN LONG TERM CARE HOME
671 FRANK STREET, P.O. BOX 10, WIARTON, ON, N0H-2T0

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

TAMMY SZYMANOWSKI (165), DEBORA SAVILLE (192), DOROTHY GINTHER (568)

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): July 2, 3, 4, 7, 8, 9, 10 and 11, 2014

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Administrator, Environmental Services Manager, Recreation and Leisure Manager, Food Service Manager (FSM), Clinical Care Co-ordinator, Resident Assessment Instrument(RAI) Co-ordinator, Infection Control Nurse, Administrative Assistant, Ward Clerk, Registered Nurses(RN), Registered Practical Nurses(RPN), Personal Support Workers(PSW), Laundry Aides, Dietary Aides, Recreation and Leisure Aides, families and residents

During the course of the inspection, the inspector(s) the inspector(s) toured the home, observed meal service, food service, medication passes, medication storage areas and care provided to residents, reviewed medical records and plans of care for identified residents, reviewed policies and procedures of the home, and observed general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
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
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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 O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that where bed rails were used the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident and steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Interview with Clinical Care Co-ordinator July 10, 2014, confirmed that where bed rails were used residents of the home have not been assessed to minimize risk to the resident.

During observation in Stage 1 of this inspection by inspectors #192, #165, and #568; 30 of 40 residents were observed to have one or more bed rails in the up position.

It was observed that where the bed rails were in the up position, beds were observed to have no keepers in place at the foot or head of bed, allowing the mattress to move out of place with minimal lateral pressure and creating a potential zone of entrapment. It was also observed that where the bed rails were in the up position, two mattresses were observed to be too small to fit the bed system.

The Environmental Manager confirmed that bed systems where bed rails were used were evaluated in 2012. It was identified that at least 33 bed systems had failed the potential zones of entrapment. On July 10, 2014, the Environmental Manager confirmed that there were still 14 bed systems that had failed the potential zones of entrapment and steps were not taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(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. (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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that there was a written plan of care for each resident that sets out clear directions for staff and others who provide direct care to the resident.

On July 3 and July 7, 2014, resident #013 was observed in bed with two quarter bed rails in the raised position. A RPN reported that the resident used two bed rails in the raised position when in bed and the Minimum Data Set(MDS)assessment indicated bed rails were used daily.

On July 3, 2014, the resident was observed getting out of bed on their own. PSW's and Registered staff interviewed confirmed that bed rails should be included in the resident's care guide located in each resident's room. The Clinical Care Co-ordinator reported that the resident used the bed rails for self transferring and positioning.

The resident's plan of care did not include the use of bed rails and on July 7, 2014, there was no resident care guide found for this resident in their room. A PSW and RPN confirmed there was no resident care guide for this resident at this time. The Clinical Care Co-ordinator confirmed the use of bed rails were not set out in the

planned care for the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

A) Resident #034's plan of care indicated the resident was to receive one to one visits twice weekly with sensory stimulation.

The Manager of Recreation and Leisure confirmed that all activity participation would be recorded in the electronic documentation system "Activity Pro".

A review of the record from Activity Pro and interview confirmed that resident #034 has not received twice weekly one to one visits with sensory stimulation for April, May, and June 2014.

B) The plan of care related to potential for injury (high risk) falls for resident #013 indicated that a bed alarm monitor was to be placed on the resident's mattress. Staff were to ensure the monitor was in use and respond to the alarm as urgent related to the residents falls risk.

On July 8, 2014, at approximately 1000 hours, the resident was laying in bed with a bed alarm in place on the mattress. The resident moved off the alarm on two occasions however, the bed alarm did not activate. The Clinical Care Co-ordinator was present and confirmed that the monitor was not in use at the time as specified in the plan of care.

C) The Treatment Administration Record (TAR) for resident #021 directed staff to cleanse and apply a treatment to the resident's skin impairment.

On July 8, 2014, at approximately 1500 hours, the resident was observed to have a different treatment applied. The Clinical Care Co-ordinator confirmed that the treatment identified on the TAR was not provided as specified and the current treatment applied was incorrect.(165) [s. 6. (7)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary.

A) The plan of care related to toileting indicated resident #013 required extensive assistance, staff bear weight to transfer resident onto toilet, resident participation was very limited.

On July 3, 2014, the resident was observed getting out of bed and transferring to the toilet independently without staff present. The Clinical Care Co-ordinator reported that the resident required extensive assistance at one time when they sustained an injury however, extensive assistance was no longer required. The Clinical Care Co-ordinator confirmed the plan of care was not revised when the care set out in the plan was no longer necessary.

B) Resident #023 sustained a fall from bed. Interview and record review confirmed that the resident complained of pain and sustained bruising and edema in identified area. Six days later, resident #023 was diagnosed to have an injury.

Interview with the resident confirmed that they require additional assistance with activities of daily living such as dressing, oral care, eating, and transferring since the injury.

Interview with Personal Support Workers confirmed that the resident's care had changed since the fall. The resident was no longer able to be as independent as they were prior to the fall with injury.

Interview with the Clinical Care Coordinator confirmed that the plan of care was not reviewed and revised with the change in condition that occurred post fall and that the expectation would be for changes in care to be assessed and the plan of care, including the Resident Care Guide posted in the residents room, to be updated with the residents assessed needs.

Interview with registered staff confirmed that the resident should have been assessed and the plan of care updated to include changes in care related to the presence of the injury.

C) The plan of care related to toileting for resident #021 indicated the resident required extensive assistance with staff bearing weight to transfer onto toilet/position on pan/ change briefs/ adjust clothes and resident participation was very limited. It indicated that one staff for physical assistance for elimination process however, the resident may require two staff if they were not weight bearing well that day.

The plan of care related to bowel continence indicated for bowel monitoring that the resident would independently toilet themselves.
The plan of care related to transfers indicated one person physical assistance, residents ability to transfer varied day to day, may require two staff and the use of a sara lift (sit to stand) if the resident was not weight bearing well.

Staff reported that the resident has had recent health changes and their care needs have changed. It was reported that the resident could not independently toilet themselves. On July 9, 2014, at approximately 1115 hours the resident was observed to require a mechanical sling lift with two staff assistance for transfer and change of brief. The Clinical Care Co-ordiantor confirmed the plan of care was not revised to reflect the residents recent change in care needs. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan and to 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, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: 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. 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, was in compliance with and was implemented in accordance with applicable requirements under the Act.

Regulation s50(2)(b)(iii) states that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident' plan of care relating to nutrition and hydration are implemented.

The home's wound care policy last dated September 6, 2012, indicated that the FSM would notify the Registered Dietitian(RD) of moderate nutritional risk residents who have delayed healing/worsening of stage I or stage II ulcers following the RD's initial skin assessment. The FSM would review nutritional intake of all residents with stage I or II skin breakdown considered at moderate nutritional risk at a minimum of quarterly, to ensure food and fluid intake was adequate. If the intake of the resident was inadequate then the FSM would notify the RD.

The Clinical Care Co-ordinator confirmed that the RD was referred for residents who sustained altered skin integrity that were identified as stage II or greater and was not referred to complete nutritional assessments for residents exhibiting altered skin integrity including skin tears.

The Clinical Care Co-ordinator confirmed that the policy did not include information required under O. Reg s. 50(2)(b)(iii). [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The home's Pain Assessment and Management Policy last dated December 1, 2010, indicated that the interdisciplinary team would conduct and document a pain assessment quarterly. Recent MDS assessments completed for resident #013 indicated the resident had moderate to mild pain daily. The resident received routine pain medication and pain medication as needed. A review of the medication administration record (MAR) indicated the resident received the as needed pain medication routinely.

A review of the clinical health record indicated there was no quarterly pain

assessment completed for this resident. The Clinical Care Co-ordinator confirmed that quarterly pain assessments were not being completed for this resident as indicated in the home's policy.

B) The policy titled Falls Prevention and Management Program effective October 18, 2010, on page 10 of 16 under section C. Post Fall Management indicated that a fall follow-up assessment would be completed in Point Click Care at 24 and 48 hours post fall.

i) Record review and interview confirmed that for resident #033 the fall follow-up assessment was completed at 24 hours post fall in June 2014, however, was not completed at 48 hours post fall. The Clinical Care Coordinator confirmed that fall follow-up assessments were not done at 48 hours post fall.

ii) Resident #013 sustained three falls over a three week period. A review of the clinical health record indicated that there was no 24 hour fall follow-up assessment completed in point click care for all three falls. The Clinical Care Co-ordinator confirmed the 24 hour fall follow-up assessments were not completed for the identified falls.

iii) The policy titled Falls Prevention and Management Program effective October 18, 2010 on page 10 of 16 under section C. Post Fall Management indicated that a resident who has fallen was to be monitored for 48 hours after a fall.

Record review and interview confirmed that resident #033 was not monitored at a minimum of each shift for 48 hours post fall in June 2014. The resident was documented to demonstrate a change in level of consciousness during the monitoring period.

iv) The home's Falls Prevention and Management Program Policy last dated October 18, 2010, indicated that a Head Injury Routine would be initiated if a fall was unwitnessed. In July 2014, resident #013 was found by activation staff and the fall incident note did not indicate if the resident hit their head at the time of the fall.

The Clinical Care Co-ordinator reported that the expectation was for a Head Injury Routine to be initiated post fall however, a review of the clinical health record indicated there was no Head Injury Routine completed post fall. The Clinical Care Co-ordinator confirmed that a Head Injury Routine was not initiated post fall despite being an

unwitnessed fall.

The licensee failed to comply with the Falls Prevention and Management Program policy.

C) The Policy titled Head Injury effective November 21, 2003, indicated that Head Injury Routine using the Head Injury Form was to be initiated when a resident falls or received a blow to the head. The Head Injury Form indicated that the resident was to be monitored every 30 minutes for two hours, hourly for four hours, every two hours for four hours, every four hours four times and every shift for 24 hours post fall.

Resident #033 sustained a fall in June 2014. Vital signs were completed and documented 10 minutes after the fall however, not again until 50 minutes later, and were not completed as scheduled on six other occasions. The resident was documented to have been confused and have an altered level of consciousness during the monitoring period. The Clinical Care Coordinator confirmed that the resident was not monitored according the Head Injury Policy.

The licensee failed to comply with the Head Injury Policy when resident #033 was not assessed every 30 minutes for two hours post fall, hourly for four hours, and every shift for 24 hours per the Head Injury Form.

D) The PSW routines dated to start March 8, 2014, indicated that PSWs were to report significant changes and or unusual behaviour immediately to the Charge Nurse as the shift progresses. The routine indicated that staff were not to wait until the end of shift, the information must be reported promptly including bruises and skin tears. The Clinical Care Co-ordinator reported that the expectation was Registered Nursing staff would be notified of a bruise and a progress note including the measurements of the bruise would be completed in the progress notes.

In July 2014, resident #001 was observed to have sustained a large bruise. A review of point of care records indicated that in July 2014, a PSW indicated the resident had discoloration on their skin. A review of progress notes indicated there was no bruising identified by Registered Nursing staff including the measurements and there was no indication that the bruise was reported by the PSW. This was confirmed by the Clinical Care Co-ordinator.

E) The home's policy titled Continence Care and dated as reviewed April 19, 2011,

indicted that each resident must be assessed for bladder and bowel functioning within seven days of admission, quarterly and with any change in condition that affects continence.

i) Record review and interview confirm that resident #023 was last assessed for continence in February 2014. The assessment was not dated and signed by the staff member completing the assessment, however, was attached to other assessments completed in February 2014.
Interview confirmed that resident #023 was to have received a quarterly continence assessment in May 2014; this was not completed.

ii) Record review and interview confirm that resident #013 was last assessed for continence in June 2013. A review of the resident's clinical health record confirmed that resident #013 was to have received a quarterly continence assessment in September and December 2013, March and May 2014; this was not completed.

iii) Record review and interview confirm that resident #021 was last assessed for continence in February 2013. A review of the resident's clinical health record confirmed that resident #021 was to have received a quarterly continence assessment in May, July and October 2013, and January, April and June 2014.

The licensee failed to comply with the Continence Care policy when residents were not assessed quarterly in 2013 and 2014.

F) The home's policy Inventory Control - Drug Disposal, index number 02-06-20 last reviewed October 1, 2012, stated that the following medications would be identified, destroyed and disposed of including; expired medication, medications with illegible labels, medications that are not labeled appropriately as per labeling standard, medications that are no longer required due to being discontinued, or when a resident was discharged or deceased.

During observation of the Emergency Drug Cart on July 10, 2014, in the presence of and confirmed by the Clinical Care Coordinator, it was observed that the Emergency Drug Cart contained three tubes of Insta-Glucose that was dated as expired in June 2014.

During observation in the 2E medication room on July 10, 2014, in the presence of and confirmed by the Clinical Care Coordinator, it was observed that carded Ativan

dispensed in June 2013, was outdated in June 2014, and had not been removed from use.

During observation in the 2E medication room on July 10, 2014, in the presence of and confirmed by the Clinical Care Coordinator, it was observed that four boxes of insulin with the names of deceased residents and marked as discontinued were being stored in the medication refrigerator.

During observation in the 2E medication room on July 10, 2014, in the presence of and confirmed by the Clinical Care Coordinator, it was observed that the refrigerator contained medication that was not labeled appropriately as per the medication standard. A box of expired Dimenhdrinate 50 miligrams without Medisystem labels was removed by the Clinical Care Coordinator. Humulin R insulin labeled as coming from the Emergency Drug Cart was observed to be open and was not labeled when opened.

During observation in the 2E medication room on July 10, 2014, in the presence of and confirmed by the Clinical Care Coordinator, it was observed that topical medication prescribed for two residents of the home for a two week period with a last dose identified as April 24, 2104, and June 10, 2014, remained in the treatment cart and were not discarded when the treatment was completed.

The home failed to comply with the Inventory Control - Drug Disposal policy when they did not destroy and dispose of expired medications, medication of deceased residents, medications that were not labeled appropriately and medications for specific treatments when the treatment course was completed.

G) The home's policy Ordering and Receiving - Receiving, index number 04-03-30, revised October 1, 2012, stated to unpack and check medications sent against Drug Record Book for accuracy and completeness, report any discrepancy to pharmacy immediately and to complete the Medication Reorder Sheet entry noting date received and were signed in the "nurses signature" box next to each medication.

Medication Reorder Sheets for February 28, 2014, to July 9, 2014, on the 2E home area were reviewed. It was confirmed with a registered staff member that of medications reordered during this time frame, only five medications where signed as having been received on the Medication Reorder Sheet and none of the entries were dated when they were received by the home.

H) The PSW routines dated to begin March 8, 2014, indicated that PSW's were to document throughout their shift. The Clinical Care Co-ordinator reported that the expectation of PSW's were to document in point of care at the time of care as they work throughout their shift not all at one time. A review of point of care records indicated staff were making multiple entries at one time.

On June 27, 2014, a PSW had documentation completed for resident #001 at 1341 hours for the 0700, 0800, 0900, 1000, 1100, and 1200 hours.
On July 3, 2014, a PSW had documentation completed for resident #001 at 1236 hours for the 0700, 0800, 0900, 1000, and 1100 hours.

Interview with the Clinical Care Co-ordinator confirmed that PSW's were not documenting in point of care at the time of care as indicated in the home's routines.

I) The home's policy titled Complaints - Response Guidelines dated August 2010, indicated that staff members were advised that if they receive a complaint from a resident, substitute decision maker, or family member they must report this to a departmental supervisor immediately.

Documentation confirmed resident #023's report that they notified nursing staff that they had money missing.

Interview with the Administrator and Director of Care confirm that they were not made aware of the missing money and no investigation had been conducted into the complaint.

Interview with the Administrator confirmed that it would be the expectation that when a complaint was received it would be brought to the attention of the Department Manager and in their absence to the Administrator.

At the time the money was reported missing, there was no DOC in the home and the reported loss should have been brought to the attention of the Administrator.

When resident #023 reported the loss of money to staff of the home it was not communicated and it was not reported to the departmental supervisor for investigation. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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, is complied with, to be implemented voluntarily.

WN #4: 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 of the long term care home failed to ensure that the home was equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

A) On July 2, 2014, at approximately 1445 hours the call bell in a resident's bedroom was wrapped around the end of the bed rail hanging down toward the floor with a pillow positioned and the residents arm resting on top of the call bell cord. A PSW stated that the call bell was not accessible for the resident.

On July 2, 2014, at approximately 1500 hours the call bell in a resident's bedroom was wrapped around the bed rail and clipped to the edge of bed that was pushed up against the wall. The resident was sitting on the opposite side of the bed. The resident stated that the call bell should not be over there because I can't get myself back there to get it. A PSW confirmed the call bell was not accessible for the resident.

On July 2, 2014, at approximately 1530 hours the resident had a call bell resting in a specified location. When asked by the inspector to activate the call bell, the resident attempted however, stated it was too low and could not activate the device as it was not accessible. A PSW confirmed the device was not accessible for this resident.

B) On July 2, 2014, at approximately 1524 hours the call bell in a resident's bedroom was not functioning when activated by inspector #568. A PSW confirmed that the call bell did not function when activated.

Interview with the Environmental Services Manager confirmed that the home did not have a schedule in place for routine maintenance of call bells. [s. 17. (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 the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the Recreation and Social Activities Program included the assistance and support to permit resident #034 to participate in activities that may be of interest to them if they are not able to do so independently.

Resident #034 is identified through record review, observation and interview to require assistance to participate in activities.

Interview with the Manager of Recreation and Leisure confirmed that participation in all activities including group events, one to one activity, pet visits, and volunteer visits would be recorded on the electronic documentation system "Activity Pro" for all residents of the home.

A) The plan of care dated as last reviewed April 29, 2014, for resident #034 indicated that they require assistance in program participation with the guidance of hands to actively participate in the program and interactions. Program preferences include special events, spiritual music, live entertainment, one to one visits and pet visits.

A review of the June 2014, Activities Calendar indicated there was a special event on June 15, 2014; 12 musical events; 2 gospel events; in addition to weekly pet visits that resident #034 may have participated in.

Record review and interview confirmed that resident #034 has not received assistance to participate in activities that may be of interest to them in June 2014, and participated in only two events in April and May 2014.

B) The plan of care for resident #001, indicated that live entertainment- Invitations and reminders for musicians, singers, Ernie's music, Bruce McGill were an intervention for the resident. Resident #001 was identified through record review, observation and interview to require assistance to participate in activities.

A review of the June 2014, Activities Calendar indicated there were 12 musical events that resident #001 may have participated in. Record review and interview confirmed that resident #001 has not received assistance to participate in activities that may be of interest to them in June 2014, and participated in only one event in May and June 2014. [s. 65. (2) (f)]

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 Recreation and Social Activities Program included the assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act: That the resident was released from the physical device and repositioned at least once every two hours.

On July 10, 2014, resident #001 was observed for a two hour period. The resident's physical device was not released and the resident was not repositioned during this time. A review of point of care records indicated that the resident did not routinely have the physical device released and repositioned every two hours.

On July 9, 2014, over a seven hour period the resident's physical device was in place however, documentation indicated the resident was not repositioned during this time period. A review of the point of care records with the Clinical Care Co-ordinator confirmed that on several occasions the resident had not been repositioned for several hours. [s. 110. (2) 4.]

2. Every licensee shall ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act: 6. That the resident's condition was reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

Resident #001 had two physical devices in place when up in their wheel chair. The Clinical Care Co-ordinator reported that the resident was capable of releasing one physical device however, the resident could not reliably release the second physical device when requested to do so. The Clinical Care Co-ordinator reported that registered nursing staff were responsible for reassessing the resident's condition and evaluating the effectiveness of the restraint in point of care.

A review of the point of care records indicated that the resident's condition was not reassessed and the effectiveness of the restraining evaluated by a member of the registered nursing staff at least every eight hours on at least six occasions during a one month period. This was confirmed by the Clinical Care Co-ordinator. [s. 110. (2) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: That the resident is released from the physical device and repositioned at least once every two hours, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee failed to ensure that a drug record is established, maintained and kept in the home for at least two years, in which the following information is recorded in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered
2. The signature of the person placing the order
3. The name, strength and quantity of the drug
4. The name of the place from which the drug is ordered
5. The name of the resident for whom the drug is prescribed, where applicable
6. The prescription number, where applicable
7. The date the drug is received in the home
8. The signature of the person acknowledging receipt of the drug on behalf of the home
9. Where a controlled substance is destroyed, including documentation as per section 136(4)

The Drug Record Book for 2E was reviewed with registered staff. The Drug Record Book did not contain records of medications that had been ordered by the home. Upon request Medication Reorder Sheets were provided and reviewed, however medications ordered were not recorded as having been received by the home. The registered staff member indicated that medications ordered are to be signed and dated when received on the Medication Reorder Sheets.

Medication Reorder Sheets for other home areas were found loosely stored in the Emergency Drug Cart room. The Clinical Care Coordinator confirmed that staff failed to sign and date when medications ordered on Medication Reorder Sheets were received.

The home was unable to produce the Drug Record Book records for the previous two year period, although it was observed that records for 2011 were available in the Emergency Drug Cart room.

The Drug Record Book was incomplete and the home was unable to produce records for the previous two years related to medications ordered and received. [s. 133.]

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 a drug record is established, maintained and kept in the home for at least two years, in which the following information is recorded in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered
2. The signature of the person placing the order
3. The name, strength and quantity of the drug
4. The name of the place from which the drug is ordered
5. The name of the resident for whom the drug is prescribed, where applicable
6. The prescription number, where applicable
7. The date the drug is received in the home
8. The signature of the person acknowledging receipt of the drug on behalf of the home
9. Where a controlled substance is destroyed, including documentation as per section, to be implemented voluntarily.

WN #8: 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,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and O. Reg. 79/10, s. 136 (3).

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).

s. 136. (5) The licensee shall ensure,
(a) that the drug destruction and disposal system is audited at least annually to verify that the licensee's procedures are being followed and are effective; O. Reg. 79/10, s. 136 (5).
(b) that any changes identified in the audit are implemented; and O. Reg. 79/10, s. 136 (5).
(c) that a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 136 (5).

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee failed to ensure that when a drug that was to be destroyed was a controlled substance, it was done 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 a physician or a pharmacist.

Interview with the Clinical Care Coordinator conducted July 9, 2014, confirmed

controlled substances that require destruction were counted by the pharmacist and confirmed by the Clinical Care Coordinator but that destruction of the controlled substance was completed by the pharmacist independently. [s. 136. (3) (a)]

2. The licensee failed to ensure that where a drug that was to be destroyed was not a controlled substance, it was done 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.

Interview with the Clinical Care Coordinator conducted on July 9, 2014, identified that drugs for destruction were placed in pail designated for drug destruction by individual registered staff of the home. The pharmacist working independently was responsible for denaturing the discarded drugs.

The licensee did not have in place a practice for drug destruction by a team acting together. [s. 136. (3) (b)]

3. The licensee failed to ensure that the drug destruction and disposal system was audited at least annually to verify that the licensee's procedures are being followed and are effective, that any changes identified in the audit were implemented and that a written record was kept.

Interview with the Director of Care confirmed that the drug destruction and disposal system has not been audited at least annually. [s. 136. (5)]

4. The licensee failed to ensure that when a drug was destroyed, the drug was altered or denatured to such an extent that its consumption was rendered impossible or improbable.

Non-narcotic drugs that have been discarded or discontinued were stored in a bin in the medication cart and then transported to a destruction bin in a locked area housing the Emergency Drug Supply cart. The non-narcotic drugs observed in the destruction bin remained in their plastic dispensing sleeve and it was confirmed that the plastic sleeve did not dissolve when liquid was applied.

Interview with the Clinical Care Coordinator confirmed that staff of the home do not denature drugs for destruction that are placed in the designated bin, It was believed that the Pharmacy Consultant may pour liquid into the bin, but this was not always

observed.

Interview with the Director of Care and Clinical Care Coordinator confirmed that the denaturing of narcotic medication is not witnessed by the DOC or Clinical Care Coordinator before they sign the destruction record for narcotic medication and they were unable to confirm that it was completed. [s. 136. (6)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a drug that is to be destroyed is a controlled substance, it is done 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 a physician or a pharmacist, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. For the purposes of paragraph 6 of subsection 76 (7) of the Act, the home failed to ensure that pain management, including pain recognition of specific and non-specific signs of pain was provided to all staff who provide direct care to residents.

Training in pain management, including recognition of specific and non-specific signs of pain was not provided to all staff who provide direct care to residents annually. The Clinical Care Co-ordinator confirmed that pain management training was not included as part of the home's mandatory education program conducted annually and was not completed in 2013. [s. 221. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that pain management, including pain recognition of specific and non-specific signs of pain is provided to all staff who provide direct care to residents annually, to be implemented voluntarily.

WN #10: 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. Every licensee of the long term care home failed to ensure that the home was a safe and secure environment for its residents.

A) On July 3, 2014, at approximately 1000 hours on Saugeen Shores home area, the tub room door was left propped open with no staff in attendance. The tub was filled with water and there was water on the floor with no signage. There were mobile residents in the home area.

A PSW interviewed confirmed that it was left open and there was water on the floor creating an unsafe environment which residents could access.

B) On July 2, 2014, at approximately 1115 hours on Saugeen Shores home area, the tub room door was left unlocked and unattended. The cabinets were unlocked containing disinfectants and there were mobile residents in the home area. The RPN confirmed it was unlocked and unattended and locked the door when notified by the inspector #568. [s. 5.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Resident #033 sustained a fall from bed in June 2014. Review of the post fall assessment completed identified that the use of bed alarm may be effective for this resident. Interview with the Clinical Care Coordinator on July 4, 2014 confirmed that a bed alarm was to be applied to resident #033's bed.

Review of the progress notes and plan of care was unable to confirm the application of the bed alarm on July 4, 2014.
Review of the progress notes and plan of care on July 7, 2014 identified the resident's response to the application of the bed alarm, but did not indicate the use of a bed alarm or when it was applied.

Observation and interview confirm that a bed alarm was in place on resident #033's bed.

Record review and interview confirm that the use of the bed alarm was not included in the medical record, including the plan of care and Resident Care Guide.

The licensee failed to ensure that interventions related to use of a bed alarm, were documented. [s. 30. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee of the long-term care home failed to ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented.

A) On June 6, 2014, the clinical health record indicated that resident #021 had skin impairment.

A review of the clinical health record indicated there was no assessment completed by the home's registered dietitian. The Clinical Care Co-ordinator confirmed that the home's registered dietitian was referred to assess residents with ulcers or wounds stage II or greater. [s. 50. (2) (b) (iii)]

2. The licensee of the long term care home failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) Resident #021 had skin impairment. A review of the Treatment Administration Record (TAR) indicated a weekly assessment of the skin impairment was to be completed every Monday.

A review of the clinical health record July 8, 2014, indicated that the weekly skin assessment was not completed as indicated on July 7, 2014. The Clinical Care Co-ordinator confirmed that the assessment was to be completed July 7, 2014 however; was not completed at the time of review. [s. 50. (2) (b) (iv)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee of the long-term care home failed to ensure that, each resident who was incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

The plan of care related to management of urinary incontinence for resident #021 indicated that staff were to toilet the resident before and after meals and on request. On July 9, 2014, the resident was observed from 0915 to 1115 hours and was not toileted during this time. At approximately 1105 hours the resident called out to the inspector stating they had to be toileted. The resident's call bell was activated and the resident reported to staff they wanted to be toileted. Fifteen minutes later staff attended to the resident and a PSW reported that the resident's incontinence product was changed however, the resident was not toileted at this time as the resident was already incontinent. Staff reported that night shift provided morning care and the resident was up at approximately 0530 hours. PSW's confirmed they did not provide morning care including toileting or changing the resident's continence product prior to 1115 hours. Staff confirmed the resident was not toileted before or after breakfast and the Clinical Care Co-ordinator confirmed that the resident's individualized plan of care was not implemented. [s. 51. (2) (b)]

WN #14: 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 respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Review of the minutes of Residents' Council identified that response to concerns from the Council was not provided within 10 days of receipt of the concern or recommendation.

Interview with the Administrator confirmed that recorded responses were not provided to Resident's Council within 10 days of receiving concerns or recommendations at the meetings held by the Council and were not shared with members of the Residents' Council until the next meeting.

In one instance the complaint was received November 25, 2013, and the response was dated as being provided January 23, 2014. Another complaint was received November 25, 2013, and the response was dated as being provided February 10, 2014.

Record review and interview confirm that concerns documented to have been expressed at the January 27, 2014, related to Nursing and Personal Care have not been responded to since the January 27, 2014, Resident Council meeting.

The November 2013 meeting, there was a request from Residents' Council to return to 0800 breakfast on the third floor. The minutes reflect adoption of the issue, that it was seconded and approved by a show of hands. It was recorded that the decision would be taken to the Director of Nursing for consideration. There was no documented response to the request and interview confirmed that a response was not provided to Residents' Council until February 19, 2014. [s. 57. (2)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 100. Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.

Findings/Faits saillants :

1. The licensee failed to ensure that written complaint procedures required under section 21 of the Act incorporate the requirements set out in section 101 of 0. Reg. 79/10.

Review of the homes policy titled Complaints-Response Guidelines dated as reviewed August 2010, identified that direction related to complaints that cannot be investigated and resolved within 10 business days was not included in the policy. The Administrator was able to describe a process used when complaints were not able to be investigated and resolved within 10 business days, but confirmed that the policy did not include information required under O. Reg s. 101(1)2. [s. 100.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

A) Resident #023 reported a sum of money to be missing to staff of the home on two occasions in June and July 2013, and to a Ministry of Health and Long Term Care Homes Inspector on July 3, 2014. Record review confirmed that the missing money was reported to staff of the home in July 2013.

Interview with the Administrator of the home conducted on July 8, 2014, confirmed that the missing money had not been investigated and no response was provided to the resident within 10 business days. [s. 101. (1) 1.]

2. The licensee failed to ensure that a documented record was kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant?

The binder containing complaints for 2012 and 2013 was reviewed. There was only one documented complaint for each of 2012 and 2013.

Interview with the Administrator and Director of Care confirmed that additional verbal and written complaints had been received by the home. Hand written notes were provided related to three complaints reviewed by the DOC, but did not include the required information.

Interview with the Administrator confirmed that the home did not maintain a documented record of each verbal and written complaint received by staff of the home. [s. 101. (2)]

3. The licensee failed to shall ensure that, (a) the documented record was reviewed and analyzed for trends at least quarterly; (b) the results of the review and analysis were taken into account in determining what improvements were required in the home; and (c) a written record was kept of each review and of the improvements made in response.

Interview with the Administrator confirmed that complaints were not reviewed and analyzed for trends at least quarterly, that the results of the review and analysis were taken into account in determining what improvements are required in the home and that a written record was kept of the review. [s. 101. (3)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee of the long-term care home failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 29 of the Act, and was done in accordance with the Act and this Regulation.

The Director of Care confirmed that an evaluation to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements were required to minimize restraining and to ensure that any restraining that was necessary was done in accordance with the Act and this regulation was not completed for 2013. [s. 113. (b)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, including the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Interview with the Director of Care conducted on July 10, 2014, confirmed that there has been no annual review of the medication management system. [s. 116. (1)]

WN #19: 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. (2) The licensee shall ensure,
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly.

The Infection Prevention and Control designate confirmed that the home did not meet quarterly and the interdisciplinary team has not met in within the past year. [s. 229. (2) (b)]

2. The licensee failed to ensure, that the program was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The Director of Care confirmed that the Infection Prevention and Control Program was not evaluated for 2013. [s. 229. (2) (d)]

Issued on this 31st day of July, 2014

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	TAMMY SZYMANOWSKI (165), DEBORA SAVILLE (192), DOROTHY GINTHER (568)
Inspection No. / No de l'inspection :	2014_202165_0018
Log No. / Registre no:	L-000679-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 17, 2014
Licensee / Titulaire de permis :	CORPORATION OF THE COUNTY OF BRUCE 671 Frank Street, WIARTON, ON, N0H-2T0
LTC Home / Foyer de SLD :	GATEWAY HAVEN LONG TERM CARE HOME 671 FRANK STREET, P.O. BOX 10, WIARTON, ON, N0H-2T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CHARLES YOUNG

To CORPORATION OF THE COUNTY OF BRUCE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall ensure that where bed rails are used, residents are assessed and their bed systems are evaluated in accordance with evidence-based practices to minimize risk to the resident. The home shall ensure that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment with bed systems that have being identified to have failed during testing.

Grounds / Motifs :

1. The licensee of the long term care home failed to ensure that where bed rails were used the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident and steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Interview with Clinical Care Co-ordinator July 10, 2014, confirmed that where bed rails were used residents of the home have not been assessed to minimize risk to the resident.

During observation in Stage 1 of this inspection by inspectors #192, #165, and #568; 30 of 40 residents were observed to have one or more bed rails in the up position.

It was observed that where the bed rails were in the up position, beds were observed to have no keepers in place at the foot or head of bed, allowing the mattress to move out of place with minimal lateral pressure and creating a potential zone of entrapment. It was also observed that where the bed rails were in the up position, two mattresses were observed to be too small to fit the bed system.

The Environmental Manager confirmed that bed systems where bed rails were used were evaluated in 2012. It was identified that at least 33 bed systems had failed the potential zones of entrapment. On July 10, 2014, the Environmental Manager confirmed that there were still 14 bed systems that had failed the potential zones of entrapment and steps were not taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. (165)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 17th day of July, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : TAMMY SZYMANOWSKI

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