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
Aug 11, 2014	2014_261522_0019	L-000681-14	Resident Quality Inspection

Licensee/Titulaire de permis

SHARON FARMS & ENTERPRISES LIMITED
1340 HURON STREET, LONDON, ON, N5V-3R3

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

KENSINGTON VILLAGE
1340 HURON STREET, LONDON, ON, N5V-3R3

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

JULIE LAMPMAN (522), NANCY JOHNSON (538), RHONDA KUKOLY (213), TERRI DALY (115)

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 15, 17, 18, 21-24, 2014

A concurrent complaint inspection 001886-14 was completed during this RQI

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Dietary Manager, Environmental Manager, Activity Manager, RAI Coordinator, four Registered Nurses, eight Registered Practical Nurses, twelve Personal Support Workers, a Restorative Aide, a Laundry Aide, two Dietary Aides, an Activity Aide, five Family Members and over forty Residents.

During the course of the inspection, the inspector(s) During the course of the inspection, the inspector(s) toured all resident home areas, the medication room, observed dining service, medication pass, provision of resident care, recreational activities, staff/resident interactions, infection prevention and control practices, reviewed resident clinical records, posting of required information and relevant policies and procedures, as well as minutes of meetings pertaining to the inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Admission and Discharge
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
Nutrition and Hydration
Personal Support Services
Quality Improvement
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Training and Orientation

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that at least once in every year, a survey is taken of the residents and their families.

Interview with the Administrator revealed that the home last completed a satisfaction survey in December 2012.

The Administrator confirmed the expectation that the home conduct an annual satisfaction survey. [s. 85. (1)]

2. The licensee failed to seek the advice of the Residents' Council and Family Council in developing and carrying out the annual satisfaction survey.

Interview with the Administrator confirmed that the home recently initiated a

satisfaction survey.

Interviews with the Residents' Council President and a member of the Family Council revealed that the home did not involve the Residents' Council or Family Council in developing and carrying out the satisfaction survey.

Interview with the Activity Manager revealed that the home did not involve the Residents' Council or Family Council in developing and carrying out the satisfaction survey.

The Administrator confirmed the expectation that the Residents' Council and Family Council is involved in developing and carrying out the satisfaction survey. [s. 85. (3)]

3. The licensee failed to document and make available to the Residents' Council and Family Council the results of the satisfaction survey.

Interviews with the Residents' Council President and a member of the Family Council confirmed that the home did not share the results of the 2012 satisfaction survey with the Councils.

The Administrator was unable to provide documented confirmation that the home made available the results of the satisfaction survey to the Residents' Council and Family Council.

The Administrator confirmed the expectation that the home document and make available to the Residents' Council and Family Council the results of the satisfaction survey. [s. 85. (4) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 a that at least once in every year, a satisfaction survey is completed and the results of that survey are documented and made available to the Residents' Council and Family Council, to be implemented voluntarily.

WN #2: 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. (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 a documented record is kept in the home that includes the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, the final resolution, every date on which any response was provided to the complainant and any response made by the complainant.

Review of the home's Complaints and Reports Policy #ADM-RR-II-085 revealed:
Complaints Review
- The administrator will keep all "Concerns" forms on file and keep a log of the type, timing, and ultimate resolution of all complaints
- Periodically, and at least once every 3 months, complaints will be reviewed and analyzed for trends, with the conclusions used to highlight areas for improvement
- A written record of such review and any consequent improvements will be maintained.

The Administrator was not able to produce any documented records related to any concerns or complaints received by the home since 2011.

The Administrator confirmed that she is aware of the requirement to keep a documented record of concerns and complaints, both verbal and written. [s. 101. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensured that all staff who provide direct care to residents receive additional training in the following areas:
1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management
4. Pain management

Review of the Home's Education Summary for 2013 revealed:
46% of direct care staff received training in Continence
25% of direct care staff received training in Falls Prevention
35% of direct care staff received training in Skin and Wound Education
24% of direct care staff received training on Pain.

Interview with the Administrator confirmed that the home has not provided training to all direct care staff in the above areas.

The Administrator confirmed the expectation that all direct care staff receive education in Falls Prevention, Continence, Skin and Wound and Pain. [s. 221. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident has his or her personal health information kept confidential.

On a specified date, a registered nursing staff was observed discarding empty medication strip packages with residents' names and medication names and doses printed on them into the regular garbage.

The Director of Care and the Administrator confirmed that the expectation is for staff to collect empty medication strip packages in a container and pour water on them to remove the personal health information prior to them being put in the regular garbage. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all resident personal health information is kept confidential, to be implemented voluntarily.

WN #5: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee did not ensure that staff and others involved in the care of a specified resident collaborated with each other in the assessment of the resident so that assessments are integrated, consistent and complement one another.

Review of an assessment for a specified resident indicated frequent bladder

incontinence. Interview with two Personal Support Workers (PSWs) revealed that the resident is continent of bladder function during the day.

On a specified day during an interview with the resident the inspector detected an odour of urine and observed a round, yellowish brown stain on the resident's sheets.

On the following day, the inspector again observed a round yellowish brown stain on the resident's top and bottom sheet. The inspector also detected the smell of urine.

Review of the resident's plan of care revealed the goal that the resident will be clean, dry and odour free daily.

Interview with the Director of Care revealed the expectation that the resident's hygiene should be maintained and the resident's sheets should be checked often to ensure they are clean and dry.

Interview with the RAI Coordinator revealed the need to review the resident's urinary incontinence and daily patterns should be initiated to ensure the assessments are integrated, consistent and complement each other. [s. 6. (4) (a)]

2. The licensee failed to ensure that staff and others involved in the different aspect of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent and complement each other.

A review of wound assessments for a specified Resident by the Wound Care Nurse, Registered Nurse, RAI Coordinator and Dietician revealed inconsistent documentation and assessment of the Resident's wound

The Director of Care confirmed that the Skin and Wound Assessments for the Resident are inconsistent and incorrect. [s. 6. (4) (a)]

3. The licensee failed to ensure that staff and others involved in the different aspect of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent and complement each other.

A review of the plan of care and wound assessments for a specified resident by the Registered Nurse and RAI Coordinator revealed inconsistent documentation and assessment of the resident's wound

The Director of Care confirmed that the Skin and Wound Assessments for the resident are inconsistent and did not complement each other. [s. 6. (4) (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 staff and others involved in the different aspect of resident care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent and complement each other, to be implemented voluntarily.

WN #6: 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. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The home's Policy 5-1 Expiry and Dating Medications indicates:
Procedure:
1. Examine the expiry date of all medications on a monthly basis. Check all storage areas for extra medication, PRN medications, narcotic medications, topical medications and eye preparations. Do not forget refrigerated items.
2. Remove any expired medications from stock and order replacement if necessary.
3. Certain medications must be dated when opened and removed from stock when expired.
4. Handle expired prescription medications as surplus medications (refer to policy on surplus medications and drug destruction)
5. Place all expired government stock medications in the drug destruction bin.
6. Return expired vaccines to public health.

Observations on a specified date revealed a container with a pharmacy label indicating "Kensington Village Stat Box. Humulin R Insulin cartridge", it contained a vial/cartridge of Humulin R insulin. The expiry date indicated on the container was April 2014. An open bottle of calamine lotion was also found on the treatment cart with an expiry date of May 2014.

A Registered Nursing Staff confirmed that these expired medications should not be in the medication room.

The Director of Care and Administrator confirmed that the Pharmacy Technician is expected to audit the medication monthly and remove expired medications and that the expired medications found in the first floor medication room should have been removed the month of their expiry as per the policy. [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 all expired medications are removed from stock, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the homes furnishings and equipment in the tub rooms are kept clean and sanitary.

Observation of the 2nd floor tub room revealed:
-The tub on the right side was missing edging around top of the tub, leaving a yellow glue-like residue.
-The base of both tub room lifts appeared dirty and discoloured.
-The flooring and walls upon entrance to the tub rooms are marked with black scuffs

In the 2nd floor tub room in the secure unit, the flooring tiles appeared dirty and dingy.

Interview with the Environmental Manager revealed the expectation that these areas be kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee failed to ensure that areas in the home are maintained in a good state of repair.

During the initial tour and throughout the inspection the home was noted to have significant paint chips throughout, especially in common areas, door frames, and doors mainly on the 2nd floor secure unit and 2nd floor Windsor dining room.

Interviews with staff revealed that due to current home renovations attention to these details have not been a priority.

Review of the homes renovation plan revealed that the 2nd floor secure unit where many of the maintenance concerns were identified, will not undergo renovation until the end of 2014.

Interview with the Environmental Services Manager and Administrator confirmed the expectation that the home be maintained in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #8: 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 failed to ensure that the resident-staff communication response system is easily accessed by residents.

A)Observation of a specified resident's shared bathroom revealed the call bell cord was tied around the grab bar attached to the bathroom counter preventing the resident from pulling the cord to activate the call bell.

This was confirmed by the Personal Support Worker.

B)Observation of a specified resident in the resident's room revealed that the resident did not have a call bell cord in the resident's room.

This was confirmed by the Personal Support Worker and the Registered Practical Nurse.

Interview with the Administrator confirmed the expectation that all residents have access to the resident-staff communication response system. [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 resident-staff communication response system is easily accessed by all residents, to be implemented voluntarily.

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 ensure that a written response is given within 10 days of receiving Residents' Council concerns or recommendations.

Interview with Residents' Council President revealed that the home does not respond in writing within 10 days of receiving Resident Council concerns or recommendations.

The Residents' Council President stated the Council recently brought forth a concern to the home.

Interview with the Administrator confirmed she was aware of the concern from the Residents' Council but the home had not responded to the Council regarding the concern.

The Administrator confirmed that the home does not respond in writing within 10 days of receiving concerns or recommendations from Residents' Council. The Administrator confirmed she was unaware of the expectation to respond to Residents' Council concerns or recommendations in writing within 10 days. [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a written response is given within 10 days of receiving Residents' Council concerns or recommendations, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a written response is given within 10 days of receiving Family Council concerns or recommendations.

Interview with a Family Council Member revealed that the home does not respond in writing within 10 days of receiving Family Council concerns or recommendations.

Interview with the Administrator confirmed that the home does not respond in writing within 10 days of receiving concerns or recommendations from Family Council. The Administrator confirmed she was unaware of the expectation to respond to Family Council concerns or recommendations in writing within 10 days. [s. 60. (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 a written response is given within 10 days of receiving Family Council concerns or recommendations, to be implemented voluntarily.

WN #11: 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 the organized recreational and social activities program includes a schedule of recreation and social activities that are offered on evenings.

During Stage 1 of the RQI resident interviews revealed a lack of activation/recreation programs in the evening.

A review of Activation Calendars for June and July 2014 revealed that an evening activity was offered 9 days out of 30 in the month of June, however 5 of these 9 activities were denominational church services.

In July 2014 evening activities were offered on 5 out of 31 days, however, 4 of these 5 activities were denominational church services.

Review of Activity staffing schedules revealed that staff are booked for day shifts only unless there is a special occasion, revealing that there are no regular evening programs. This was confirmed by an Activation Aide.

An interview with the Activity Manager and the Administrator revealed the expectation that there would be adequate programming in the evening for residents to enjoy.

The Administrator confirmed the expectation that the home offer evening activities to the residents. [s. 65. (2) (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 there is a schedule of recreation and social activities that are offered to residents in the evening, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee failed to consult at least every three months with Residents' and Family Council.

A)Interview with the Residents' Council President and review of Residents' Council meeting minutes revealed that the Administrator had not attended Residents' Council meetings since the beginning of 2014.
Residents' Council President revealed the Administrator did not regularly consult with Residents' Council.

B)Interview with a Family Council member and review of Family Council meeting minutes revealed that the Administrator had not attended Family Council meetings since March 2014. The Family Council member stated there has been no communication with the Family Council since that time.

Interview with Administrator revealed that it had been quite awhile since the previous Administrator had met with Residents' and Family Council and the Administrator had not met with Residents' and Family Council at least every three months.

The Administrator confirmed the expectation that Residents' and Family Councils are consulted at least every three months. [s. 67.]

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 Residents' Council and Family Council are consulted regularly, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (6) Every licensee of a long-term care home shall ensure that the following are done:
1. The further training needed by the persons mentioned in subsection (1) is assessed regularly in accordance with the requirements provided for in the regulations. 2007, c. 8, s. 76. (6).
2. The further training needs identified by the assessments are addressed in accordance with the requirements provided for in the regulations. 2007, c. 8, s. 76. (6).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff training needs are assessed at least annually.

Review of the homes Continuous Quality Improvement meeting minutes from June 2014 revealed that in May 2014 the team identified the need to develop a plan for education and training of staff.

Review of the Staff Development Program: Orientation and Training Program Evaluation from January 2013 - December 2013 revealed that a needs assessment of staff training had not been completed within the past 12 months. The report indicated in the area for improvement that a needs assessment for staff needs to be completed.

Interview with the Administrator confirmed that the home did not assess staff training needs annually. The Administrator confirmed the expectation that staff training needs are assessed at least annually. [s. 76. (6) 1.]

2. The licensee failed to ensured that all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive additional training in the following areas:

1. Mental health issues, including caring for persons with dementia
2. Behaviour management
3. Palliative care

Interview with the Administrator and review of direct care staff training for 2013 revealed
60% of direct care staff were trained in Responsive Behaviours, and 35% of direct care staff were trained in Palliative Care. There was no formal Mental Health training in 2013.

The Administrator confirmed the expectation that all direct care staff receive training in Responsive Behaviours, Palliative Care and Mental Health. [s. 76. (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 staff training needs are assessed annually and all direct care staff receive additional required training, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure all required information is posted in the home.

Tour of the home by inspectors #538 and #213 on July 15, 2014 revealed the absence of required postings other than the Ministry Actionline.

The Administrative Assistant was able to provide a copy of an inspection report dated July 2013 but copies of reports and orders by an inspector that have been made in the past two years were inaccessible.

The Director of Care confirmed that a binder containing inspection reports made within the past two years was missing from the first floor nurses station.

Tour of the home with the Administrator and Inspector #522 on July 17, 2014 revealed the absence of the following required postings:
Family Council most recent minutes
Home's Mission Statement
Home's Policy to Promote Zero Tolerance of abuse and neglect of residents
Whistle Blowing Protection
Home's Procedure for Making a Complaint
Home's Policy to minimize the restraining of Residents and how to receive a copy of the policy
Explanation of measures to be taken in case of a fire
Explanation of evacuation procedures

Copies of the inspection reports and orders by an inspector that have been made in the past two years and copies of Resident Council Minutes were in a binder on the wall beside the 1st floor nurses station. Administrator confirmed that the binders were not posted in a conspicuous and easily accessible location.

Administrator confirmed all required postings were not posted and was unaware of legislation regarding the required postings in the home. [s. 79. (3) (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 all required information is posted in the home, in a conspicuous and easily accessible location, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee failed to ensure that no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs.

Review of resident clinical records revealed specified residents have all available medical directives ordered by the physician and available for use including Glucagon Inject and Nitroglycerin Spray. These residents do not have a diagnoses of diabetes or angina.

A registered nursing staff, the Director of Care and the Administrator confirmed that all residents have all possible medical directives ordered for them on admission and re-ordered every 3 months regardless of their individual diagnosis or needs; there was no system in place for the physician to order medical directives according to the resident's individual condition and needs. They confirmed that there is risk to residents having medical directives ordered when they are not appropriate for their condition and needs.

The Director of Care and the Administrator confirmed that they understand that medical directives should be ordered and used according to each resident's individual condition and needs. [s. 117. (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 medical directives are individualized to the resident's condition and needs, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

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Findings/Faits saillants :

1. The licensee failed to ensure that where a drug is to be destroyed is not a controlled substance, it will be 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. Drug destruction is considered to be destroyed when it is altered or denatured to such an extent that it's consumption is rendered impossible or improbable.

Staff interview with two Registered Nursing Staff Members revealed that the Registered Nursing Staff discard unused or discontinued medications into a locked green bin which pharmacy picks up and takes for destruction. The Registered Nursing Staff do not participate in medication destruction and they do not alter or denature any medications before they are picked up by pharmacy.

The Director of Care and the Administrator were unaware of the process for medication destruction of non-controlled substances other than that pharmacy collects the green bins and Stericycle removes the medications for destruction. They were unaware of the expectation as outlined in the legislation that non-controlled medications are altered or denatured by a team including Registered Nursing Staff of the home. [s. 136.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all non-controlled substances to be destroyed are denatured by a team acting together, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement

Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:

1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.

2. The system must be ongoing and interdisciplinary.

3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.

4. A record must be maintained by the licensee setting out,

i. the matters referred to in paragraph 3,

ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and

iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee failed to ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents are communicated to Residents' Council and Family Council.

A)Interview with Residents' Council President revealed that the President was unaware of the requirement that the licensee was to communicate improvements made through the quality improvement and utilization review system. Residents' Council President revealed there has been no communication to Residents' Council since 2013 related to the current renovations at the home.

Review of the Residents' Council minutes for 2014 revealed no communication regarding improvements made through the homes quality improvement program.

B)Interview with a member of the Family Council revealed that the member was unaware of the requirement that the licensee was to communicate improvements made through the quality improvement and utilization review system. The Family Council member revealed there has been no communication to Family Council since 2013 related to the current renovations at the home.

Review of the Family Council minutes for 2014 revealed no communication regarding improvements made through the homes quality improvement program.

Interview with the Administrator revealed the Administrator was unaware of the requirement and confirmed the home did not communicate improvements made through the quality improvement and utilization and review system to the Residents' Council. [s. 228. 3.]

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 improvements made through the quality improvement and utilization review system are communicated to Residents' Council and Family Council, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program.

During resident observation in the North Tubroom Secure Unit the following was found:
-an unlabelled hair brush and comb in the tub room, a spare pillow on a chair with plastic covering that was worn and cracked
-an empty urine specimen container and toothbrush holder were found on the floor behind the portable storage drawer.
Observation of a specified room revealed a labelled slipper bed pan stored on the back of the toilet.
Observation of the first floor the tub room revealed an unlabelled urinal hanging on the hand rail beside the toilet.

The Inspector also observed two wheelchair table tops and a padded bedside rail pad stored on the floor in the shower room.

Interview with a Personal Support Worker confirmed that these items are not to be stored in the tub room. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.

On specified dates, a specified resident was observed sitting in a wheelchair with a seat belt on.

Review of the resident's Clinical Record revealed the absence of a documented PASD assessment. Further record review revealed the absence of documentation in the resident's Care Plan related to the use of a PASD.

Interview with the Registered Practical Nurse(RPN) revealed that the resident does wear a seat belt while seated in the wheelchair. The RPN confirmed the absence of a documented PASD assessment and the lack of documentation regarding a PASD in the resident care plan.

Interview with the Personal Support Worker (PSW) confirmed the use of a seat belt for the resident while the resident is in the wheelchair. The PSW confirmed the absence of documentation in the resident's electronic and hard copy clinical record regarding the use of a seat belt for the resident while the resident is in the wheelchair.

The Administrator confirmed the expectation that an assessment of the resident is completed prior to the use of a PASD and that the plan of care be updated to include the use of the PASD. [s. 33. (3)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances are kept inaccessible to residents at all times.

On a specified date, in the north hallway on the first floor, a utility room door with a key pad entry was able to be opened without entering the code. This room contained toilet bowl cleaner, Virex, and spray air deodorizer.

The Administrator confirmed that this room should be closed and locked at all times and that the lock was broken. [s. 91.]

WN #21: 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 controlled substances are stored in a separate, double-locked stationary cupboard in a separate locked area within the locked medication cart.

On a specified date, the narcotic bin in the medication cart in the first floor medication room was observed to be unlocked. Staff were not in the medication room and were not using the cart at the time.

The Director of Care was in the room and observed and confirmed that the narcotic bin was found unlocked and confirmed the expectation that staff ensure that the narcotic bins in the medication carts are kept locked at all times when not in use. [s. 129. (1) (b)]

Issued on this 26th day of August, 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) :	JULIE LAMPMAN (522), NANCY JOHNSON (538), RHONDA KUKOLY (213), TERRI DALY (115)
Inspection No. / No de l'inspection :	2014_261522_0019
Log No. / Registre no:	L-000681-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 11, 2014
Licensee / Titulaire de permis :	SHARON FARMS & ENTERPRISES LIMITED 1340 HURON STREET, LONDON, ON, N5V-3R3
LTC Home / Foyer de SLD :	KENSINGTON VILLAGE 1340 HURON STREET, LONDON, ON, N5V-3R3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michael Schmidt

To SHARON FARMS & ENTERPRISES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA, 2007 S.O. 2007, s. 85. (3) to ensure the licensee seeks the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

Please submit the plan in writing to Julie Lampman, Long Term Care Homes Inspector - Nursing, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th floor, London, Ontario, N6A 5R2, by email, at julie.lampman@ontario.ca by August 18, 2014.

Grounds / Motifs :

1. 1)The licensee failed to seek the advice of the Family Council in developing and carrying out the annual satisfaction survey, and in acting on its results.
Interview with the Administrator confirmed that the home recently initiated a satisfaction survey.
Interview with a member of the Family Council revealed that the home did not involve the Family Council in developing and carrying out the satisfaction survey.

Interview with the Activity Manager revealed that the home did not involve the Family Council in developing and carrying out the annual satisfaction survey.
The Administrator confirmed the expectation that the Family Council is involved in developing and carrying out the satisfaction survey.

2)The licensee failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.
Interview with the Administrator confirmed that the home recently initiated a satisfaction survey. Interview with the Resident Council President revealed that the home does not involve the Residents Council in developing and carrying out the satisfaction survey.
Interview with the Activity Manager revealed that the home did not involve the Residents' Council in developing and carrying out the annual satisfaction survey.

The Administrator confirmed the expectation that the Residents' Council is involved in developing and carrying out the satisfaction survey, and in acting on its results.
This issue of non-compliance was previously issued as a WN on February 21, 2012 during a RQI type inspection. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 27, 2014

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(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 in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Order / Ordre :

The licensee must ensure that a documented record is 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 in turn by the complainant.

Grounds / Motifs :

1. The licensee failed to ensure that a documented record is kept in the home that includes the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, the final resolution, every date on which any response was provided to the complainant and any response made by the complainant.

Review of the home's Complaints and Reports Policy #ADM-RR-II-085 revealed:
Complaints Review
- The administrator will keep all "Concerns" forms on file and keep a log of the type, timing, and ultimate resolution of all complaints
- Periodically, and at least once every 3 months, complaints will be reviewed and analyzed for trends, with the conclusions used to highlight areas for improvement
- A written record of such review and any consequent improvements will be maintained

The Administrator was not able to produce any documented records related to any concerns or complaints received by the home since 2011. The Administrator confirmed that she is aware of the requirement to keep a documented record of concerns and complaints, both verbal and written.
(213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 18, 2014

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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:

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O.Reg. 79/10, r. 221. (1) to ensure that all staff who provide direct care to residents receive additional training in the following areas:

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management
4. Pain management

Please submit the plan in writing to Julie Lampman, Long Term Care Homes Inspector - Nursing, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th floor, London, Ontario, N6A 5R2, by email, at julie.lampman@ontario.ca by August 18, 2014.

Grounds / Motifs :

1. This issue of non-compliance was previously issued as a WN,VPC on February 21, 2012 during a RQI type inspection. The licensee failed to ensured that all staff who provide direct care to residents receive additional training in the following areas:

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management
4. Pain management

Review of the Home's Education Summary for 2013 revealed:
46% of direct care staff received training in Continence
25% of direct care staff received training in Falls Prevention
35% of direct care staff received training in Skin and Wound Education
24% of direct care staff received training on Pain.

Interview with the Administrator confirmed that home has not provided training to all direct care staff in the above areas.

The Administrator confirmed the expectation that all direct care staff receive education in Falls Prevention, Continence, Skin and Wound and Pain.
(522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 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 11th day of August, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julie Lampman

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