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**
**Direction de l'amélioration de la performance et de la conformité**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 24, 2015 | 2015_226192_0051 | 015266-15 | Complaint |

### Licensee/Titulaire de permis

LAPOINTE-FISHER NURSING HOME, LIMITED
1934 DUFFERIN AVENUE WALLACEBURG ON N8A 4M2

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

LAPOINTE-FISHER NURSING HOME
271 METCALFE STREET GUELPH ON N1E 4Y8

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

DEBORA SAVILLE (192)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): September 2, 3, 4, 9, 11, and 14, 2015.**

**This Complaint Inspection related to Resident Rights was completed concurrently with Follow-up Inspection 008380-15/008381-15 and Complaint Inspection 023200-15.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Resident Assessment Instrument (RAI) Coordinator, Personal Support Workers, Registered Practical Nurses, Registered Nurses, residents and family members.**

**The inspector toured the home, observed the provision of care, reviewed incident reports and investigation notes, medical records, complaint records and policy and procedure.**

**The following Inspection Protocols were used during this inspection:**
**Dignity, Choice and Privacy**

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

- **5 WN(s)**
- **4 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 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:**
**4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was respected and promoted.

A) Interview with resident #002, identified that their needs were not always addressed in a timely manner. The resident indicated that they have pulled the call bell for assistance from staff and have had to wait for long periods of time. The resident indicated that on two or three occasions they have been incontinent of bladder as a result of waiting. Resident #002 also indicated that staff would come into the room, turn off the call bell and exit the room without providing assistance.

Interview with resident #002 identified that on a specified date they activated the call bell to ask for assistance. The resident indicated that the staff member responding to the call bell was short with the them and failed to demonstrate patience in dealing with the resident's needs. The resident became visibly upset and tearful as a result of speaking about the event, stating that the staff member "was nasty with me". The resident indicated that there had been previous incidents with this staff member, when assistance was not provided as needed by the resident.

B) Interview with two family members for resident #001, indicated that staff of the home were not responsive to requests for assistance, would come in and turn off the call bell and would exit the room without providing assistance. The family members indicated they have received phone calls from resident #001 indicating that the resident needed

assistance, but that no one had come to help.

Resident #001 was observed to require staff assistance on a specified date, the call bell had been activated, no staff were in attendance.

Interview with resident #001, identified that they have, at times, had to wait for more than a half hour for assistance. The resident indicated that they require assistance with all aspects of care.

C) Resident #003 was observed prior to lunch and again one hour after lunch service had started. The resident continued to sit in the same location, food covered the resident's face, they were unshaven and were requesting assistance back to their room. The resident stated they had asked a lady to take them to their room, however "she never came back." At 1315 hours, a staff member provided assistance to the resident.

The licensee failed to ensure that every resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was respected and promoted. [s. 3. (1) 4.]

2. The licensee has failed to ensure that every resident's right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference, was fully respected and promoted.

Resident #001 was readmitted to the home from hospital. Following readmission the home restricted the residents visitors.

In spite of requests from resident #001's family to have the visitors restrictions reconsidered, the home had refused to reconsider the restrictions.

Interview with the resident, confirmed that the visitor had been visiting daily and had provided companionship to the resident. Resident #001 identified that they were lonely as a result of no longer being able to visit with the designated person.

Interview with the Substitute Decision Maker and other family members confirmed a negative impacted as a result of the restricted visitation.

The licensee failed to ensure that every resident's right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without

interference, was fully respected and promoted. [s. 3. (1) 14.]

***Additional Required Actions:***

***CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).**

**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).**

**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 has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A) The plan of care for resident #001 indicated under Toileting that the resident required extensive assistance of two staff for the entire process and that the resident required no

toileting.

The plan of care indicated under Transferring that resident #001 used an assistive device and could not weight bear.

Interview with the resident confirmed that staff use an assistive device for all transfers and interview with the Director of Care confirmed that the plan of care was unclear and could be confusing for staff and others who provide direct care to the resident.

B) The plan of care for resident #001 under Decreased/Lack of Speech indicated that the resident had an inability to express emotion and share information, related to a decline in cognitive status and a language barrier. Interventions included providing reassurance and speaking in simple terms so the resident could understand what was being done for them.

During interview, the resident was orientated to person, place and time and demonstrated an understanding of their long-term care placement and assistance required. The resident stated that no staff speak to them in their primary language, but that they are able to make staff understand their needs .

Interview with the family of resident #001 identified that the resident had no schooling and was illiterate.

The plan of care indicated that the resident had impaired vision requiring large print books.

The Administrator indicated that a communication tool had been initiated for the resident and staff use. The communication tool was observed and was found to contain written phrases and small pictures of items that might be commonly used. During interview the resident threw the communication tool across the room when the inspector attempted to use it. During a subsequent interview the resident indicated that the staff do not use the tool.

Interview with the Director of Care confirmed that the plan of care failed to provide clear direction for staff in relation to resident #001's communication needs. [s. 6. (1) (c)]

2.The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Resident #001 was admitted to the home from the hospital. At the time of admission the resident demonstrated signs and symptoms of a delirium and the plan of care reflected the resident's needs based on information from the hospital and Community Care Access Centre assessments. Assessments related to pain, bladder and bowel continence, and falls were not completed at the time of admission.

Following admission, resident #001 had medication changes and adjusted to their new surroundings.

At the time of reassessment, three months later, resident #001 was not able to participate in the assessment. The home was unable to establish how the resident's cognitive status was assessed and no pain, bladder or bowel assessments were conducted.

The Administrator and Director of Care confirmed that assessments completed were not done in a manner facilitating resident participation.

The family of resident #001 were interviewed and identified that the resident's cognitive status had improved from the time of admission and that the resident's condition was generally improved.

The Resident Assessment Instrument (RAI), section B, Cognitive Patterns, for the three month reassessment, indicated that resident #001 had memory problems with short and long term memory, had no recall of the current season, location of room, staff faces/names, or that they were in a long term care home. The assessment indicated the resident's daily decision making was moderately impaired and that their had been no change from admission.

During interview with resident #001, it was evident that the resident was orientated to person, place and time. They were able to verbalize that they were in long-term care, the reason for admission and plans for alternative care that were being investigated. They demonstrated accurate recall of incidents occurring during their stay in the home, expressed insight into the effect of decisions made as a result of those incidents and were clearly able to articulate their preferences related to transfers and toileting.

The licensee failed to ensure that the plan of care for resident #001 was based on an assessment of the resident and the needs and preferences of the resident. [s. 6. (2)]

3. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A) Resident #001 was identified in the plan of care, to have impaired vision, to have feelings of anxiety, uneasiness and depression related to sleeplessness and family identified at the time of admission that the resident was at risk of falling with a history of a injury related to a fall.

The Resident Assessment Protocol (RAP) completed following admission indicated that the resident had sustained a fall in the previous 31-180 days and remained at risk for falls.

Record review identified that resident #001 was found to be climbing out of bed on a specified date in 2015 and a bed alarm was in place.

The Side Rail Review conducted in 2015, indicated that the resident had no visual impairment, did not exhibit any anxiety, agitation or restlessness, had not climbed out of bed and that the resident was not at risk for falls.

The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

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

The plan of care for resident #001 indicated that the resident was to be weighed every Sunday and sudden weight gains were to be reported to the physician.

Record review identified that weights were not completed on specified dates in 2015 as required in the plan of care.

The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

5. The licensee has 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 changed or care set out in the plan was no longer necessary.

A) The plan of care for resident #001 indicated under risk of falls, that the resident was to have a personal alarm and a blue fall mat in place at the bedside.

The resident was admitted and at the time of admission the family identified a concern that the resident may be at risk of falling related to a previous fall with injury. Record review confirmed by the Director of Care indicated that a blue fall mat was placed at the resident's bedside.

Observation on September 3, 9 and 11, 2015 identified no fall mat was in place at the residents bedside. The resident's call bell was located where it would be accessible and the bed was noted to be in the lowest position.

The fall assessment completed on a specified date in 2015 indicated the resident was at moderate risk of falls and a Falls Resident Assessment Protocol (RAPs) was completed indicating no change in the plan of care.

Interview with the Director of Care identified that the fall mat had been removed as it had been damaged and confirmed that the plan of care had not been revised to reflect that the resident no longer used a blue fall mat.

There was no indication in the medical record that the resident's fall risk was reassessed to determine the safety of the resident without the fall mat in place.

The licensee failed to ensure that resident #001 was reassessed and the plan of care revised when care set out in the plan was no longer necessary.

B) The plan of care for resident #001 indicated that staff were to ensure that a specified treatment was provided to the resident.

Resident #001 was observed on September 3 and 9, 2015, without the specified treatment in place.

Interview with the Director of Care confirmed that the resident no longer required the treatment through the day and that it was used at night only.

The Director of Care confirmed that the plan of care had not been updated to include this change in care needs for resident #001. [s. 6. (10) (b)]

***Additional Required Actions:***

***CO # - 003 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 ensuring that the plan of care sets out clear direction to staff and others who provide direct care to the resident; ensuring that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments are integrated, consistent with and complemented each other; ensuring that care set out in the plan of care is provided to the resident as specified in the plan and ensuring 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 changed or care set out in the plan is no longer necessary, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 10. Health conditions, including allergies, pain, risk of falls and other special needs.

Resident #001 was admitted to the home after having sustained a fall with injury.

The day following admission, the family members expressed concern that the resident may sustain a fall from bed.

On the day following admission a bed alarm and fall mat were initiated related to fall risk.

Record review identified that on a specified date, resident #001 was found attempting to climb out of bed.

Minimum Data Set assessment indicated that the resident remains at risk for falls.

The plan of care related to falls was initiated on a specified date.

Interview with the Director of Care confirmed record review that no fall risk assessment had been completed for the resident.

The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of risk of falls with respect to resident #001. [s. 26. (3) 10.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 10. Health conditions, including allergies, pain, risk of falls and other special needs, to be implemented voluntarily.***

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**WN #4: 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,**
**(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for the assessment of incontinence.

Resident #001 was admitted to the home and was identified to be incontinent of bowel and bladder.

A Bowel Continence Assessment initiated but not completed, at the time of admission, indicated that resident #001 was able to recognize the time and place to defecate and was able to feel the urge to defecate which would indicate that the resident may have had some potential to maintain continence. The assessment indicated the resident was unable to participate in the program due to a language barrier and non-compliance.

The plan of care for resident #001 indicated under toileting that the resident required no toileting and under bowel incontinence that the resident was incontinent of bowels.

Record review indicated that on admission family requested that the resident be toileted using a commode. On a specified date the medical record indicated that the resident wanted to be toileted when they asked.

Interview with the Director of Care, confirmed that Bladder and Bowel Continence assessments had not been completed for resident #001 since admission and that resident #001 was no longer toileted for bowel or bladder.

The licensee failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for the assessment of incontinence. [s. 51. (2) (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 ensuring that each resident who is incontinent receives an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for the assessment of incontinence, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management**

**Specifically failed to comply with the following:**

**s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

Resident #001 was admitted to the home from hospital. The resident had sustained an injury prior to admission and at the time of admission was on narcotic analgesic four times daily and as necessary and other analgesic three times daily.

No plan of care was initiated in relation to the pain.

The home's admission policy dated as reviewed February 13, 2015, indicated that a pain assessment was to be completed at the time of admission.

The Resident Assessment Protocol (RAP) indicated that the resident had pain and generalized discomfort. The Minimum Data Set (MDS) assessment indicated the resident had moderate pain daily.

On a specified date in 2015, the resident complained of moderate pain that was calculated to be a 6 of 10 on the Abbey Scale.

Interview with the Director of Care confirmed that no pain assessment using a clinically appropriate instrument specifically designed for that purpose was completed at the time of admission or when the analgesic was discontinued.

Resident #001 was admitted to hospital in 2015 with complaints of pain. No pain assessment was completed.

The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (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 ensuring that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.***

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**Issued on this 17th day of November, 2015**

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

**Original report signed by the inspector.**

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**

## Licensee Copy/Copie du titulaire de permis

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | DEBORA SAVILLE (192) |
| **Inspection No. / No de l'inspection :** | 2015_226192_0051 |
| **Log No. / Registre no:** | 015266-15 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Sep 24, 2015 |
| **Licensee / Titulaire de permis :** | LAPOINTE-FISHER NURSING HOME, LIMITED<br>1934 DUFFERIN AVENUE, WALLACEBURG, ON, N8A-4M2 |
| **LTC Home / Foyer de SLD :** | LAPOINTE-FISHER NURSING HOME<br>271 METCALFE STREET, GUELPH, ON, N1E-4Y8 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Laura Black |

To LAPOINTE-FISHER NURSING HOME, 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) (a)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

**Order / Ordre :**

The licensee shall ensure that residents #001 and #003 and all other residents are properly sheltered, fed, clothed, groomed and cared for in a respectful and courteous manner that is consistent with their needs.

The plan of care for resident #001 will be reviewed and a plan of care developed to ensure that their continence needs are addressed in a manner that promotes independence and dignity.

It is noted that resident #002 is no longer a resident of the home.

**Grounds / Motifs :**

1. Previously issued March 13, 2014 as a WN and March 4, 2015 as a VPC.

The licensee has failed to ensure that every resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was respected and promoted.

A) Interview with resident #002 on September 11, 2015, identified that their needs were not always addressed in a timely manner. The resident indicated that they have pulled the call bell for assistance from staff related to toileting and have had to wait for long periods of time. The resident indicated that on two or three occasions they have been incontinent of bladder as a result of waiting. Resident #002 also indicated that staff would come into the room, turn off the call bell and exit the room without providing assistance.

Interview with resident #002 identified that on September 10, 2015 at 2100 hours they activated the call bell to ask for assistance to the bathroom. The staff member responding to the call bell stated to the resident "I was just in the room". The resident became visibly upset and tearful as a result of speaking about the event, stating that the staff member "was nasty with me". The resident stated "I even said, if you don't want to help me, you don't have to, others will." The resident indicated that there had been previous incidents with this staff member, when assistance was not provided as needed by the resident.

B) Interview with two family members for resident #001, indicated that staff of the home were not responsive to requests for assistance, would come in and turn off the call bell and would exit the room without providing assistance. The family members have received phone calls from resident #001 indicating that the resident needed assistance related to incontinence, but that no one had come to help.

Resident #001 was observed on September 9, 2015 at approximately 1400 hours to be incontinent of bowel, a soiled brief was laying on the floor and bed linens were heavily soiled, the call bell had been activated, no staff were in attendance.

Interview with resident #001 on September 14, 2015, with the aid of an interpreter, identified that they have, at times, had to wait for more than a half hour for assistance. The resident indicated that they require assistance with all aspects of care.

C) Resident #003 was observed at 1215 hours on September 14, 2015 at the end of the corridor on the second floor. At 1257 hours, the resident continued to sit in front of the window, food covered the resident's face, they were unshaven and were requesting assistance back to their room. The resident stated they had asked a lady to take them to their room, however "she never came back." At 1315 hours, a staff member provided assistance to the resident.

The licensee failed to ensure that every resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was respected and promoted. (192)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 16, 2015

**Order # / Ordre no :** 002

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

**Order / Ordre :**

The licensee shall meet with resident #001 and their family to develop a plan that will ensure that resident #001's right to communicate in confidence, receive visitors of their choice and to consult in private with any person without interference are fully respected and promoted.

The plan will include a schedule of review to facilitate ongoing input into the effectiveness of the plan from the resident and their family.

The plan shall be submitted electronically to Inspector Debora Saville of the London Service Area Office of the Ministry of Health and Long Term Care at debora.saville@ontario.ca by end of day October 8, 2015.

The plan shall be implemented.

**Grounds / Motifs :**

1. The licensee has failed to ensure that every resident's right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference, was fully respected and promoted.

Resident #001 was readmitted to the home on June 2, 2015, from hospital. Following readmission an incident occurred that resulted in the home issuing a no trespass letter to resident #001's power of attorney (POA) and primary care giver on June 3, 2015.

In spite of requests from resident #001's family to have the no trespass letter reconsidered, and expression of the hardship imposed on the family and the resident as a result of the no trespass letter, the home had refused to reconsider the letter.

Interview with the resident on September 14, 2015, confirmed that the POA had been visiting daily and had provided companionship to the resident. Resident #001 identified that they were lonely as a result of no longer being able to visit with the POA. The resident also indicated that the POA acted as a liaison between the resident and staff, minimizing the impact of the language barrier on the resident.

The resident's primary language is Italian and the Administrator and Director of Care confirmed that few staff in the home speak Italian.

Interview with the POA and other family members confirmed that the entire family was negatively impacted by the no trespass letter.

The licensee failed to ensure that every resident's right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference, was fully respected and promoted. (192)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 15, 2015

**Order # / Ordre no :** 003

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

**Order / Ordre :**

The licensee shall ensure that care set out in the plan of care is based on assessment of resident #001 and that the needs and preferences of the resident are included in the plan of care.

Consideration of the residents preferred language will be given when assessing the resident, ensuring that the resident is involved in the assessment.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Resident #001 was admitted to the home on April 16, 2015 from the hospital. At the time of admission the resident demonstrated signs and symptoms of a delirium and the plan of care reflected the resident's needs based on information from the hospital and Community Care Access Centre assessments. Assessments related to pain, bladder and bowel continence, and falls were not completed at the time of admission.

Following admission, resident #001 had medication changes and adjusted to their new surroundings.

At the time of reassessment in July 2015, resident #001 was not provided assessment in their first language. The home was unable to establish how the resident's cognitive status was assessed and no pain, bladder or bowel assessments were conducted.

The primary language for resident #001 was Italian. The Administrator and Director of Care confirmed that only a few of the staff of the home spoke Italian, no registered staff spoke Italian and no interpreter or family member was utilized to assist in completing the assessments.

The family of resident #001 were interviewed and identified that the resident's cognitive status had improved from the time of admission and that the resident's condition was generally improved.

The Resident Assessment Instrument (RAI), section B, Cognitive Patterns, completed on July 21, 2015 indicated that resident #001 had memory problems with short and long term memory, had no recall of the current season, location of room, staff faces/names, or that they were in a long term care home. The assessment indicated the resident's daily decision making was moderately impaired and that their had been no change from admission.

During interview with resident #001 conducted on September 14, 2015 with the assistance of an interpreter, it was evident that the resident was orientated to person, place and time. They were able to verbalize that they were in long-term care because they were unable to manage at home and that efforts to arrange care in the home had been investigated. They demonstrated accurate recall of incidents occurring during their stay in the home, expressed insight into the effect of decisions made as a result of those incidents and were clearly able to articulate their preferences related to transfers and toileting.

The licensee failed to ensure that the plan of care for resident #001 was based on an assessment of the resident and the needs and preferences of the resident. (192)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 16, 2015

## 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 24th day of September, 2015**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** DEBORA SAVILLE

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