
WN #34: 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's quality improvement and utilization review system does not consistently provide written descriptions for goals and objectives for each of the required programs and a process to identify initiatives for review.

Discussion with the Administrator and documentation review confirmed that the home does not have a process for identifying initiatives for review within the quality improvement and utilization review system. [s. 228. 1.]

2. The licensee failed to ensure that the home maintains a record of the names of persons who participated in evaluations and the dates improvements were implemented.

Interview and documentation review confirm that there is no record of the names of persons who participated in evaluations and the dates improvements were implemented. [s. 228. 4. ii.]

3. The licensee failed to ensure that the home maintained a record of the communication made to Residents' Council, Family Council and the staff of the home regarding the improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents.

Review of the minutes of Residents' Council and Family Council did not find included, documentation of improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents of the home.

Interview with the Administrator confirms that no record is kept of communication to the Residents' Council and Family Council beyond what is recorded in the minutes for these Councils. [s. 228. 4. iii.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #902	2014_226192_0001	192
O.Reg 79/10 s. 9. (1)	CO #901	2014_226192_0001	192

Issued on this 4th day of February, 2014

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

Debora Saville (192)

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) :	DEBORA SAVILLE (192), NUZHAT UDDIN (532), SHERRI GROULX (519), TAMMY SZYMANOWSKI (165)
Inspection No. / No de l'inspection :	2014_226192_0001
Log No. / Registre no:	L-000003-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 7, 14, 31, 2014
Licensee / Titulaire de permis :	LAPOINTE-FISHER NURSING HOME, LIMITED 1934 DUFFERIN AVENUE, WALLACEBURG, ON, N8A-4M2
LTC Home / Foyer de SLD :	LAPOINTE-FISHER NURSING HOME 271 METCALFE STREET, GUELPH, ON, N1E-4Y8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PEGGY KNOX

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

To LAPOINTE-FISHER NURSING HOME, LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee shall ensure that doors leading to laundry chutes are equipped with locks to restrict unsupervised access to those areas by residents, and ensure those doors are kept closed and locked when they are not being supervised by staff.

Grounds / Motifs :

1. The licensee failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

During initial tour of the home on January 7, 2014 at 1035 and at 1415 it was observed that the laundry chute rooms and laundry chutes on the first and second floors of the home were not locked and they were not being supervised by staff.

The doors were not locked to restrict unsupervised access. (192)

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

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

Order # / Ordre no : 902

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall immediately assess resident #238 and evaluate the bed system to minimize the entrapment risk to the resident.

Interventions to prevent resident entrapment shall be initiated immediately taking into consideration all potential zones of entrapment.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

In 2014 documentation review identified that resident #238 was found to have become entrapped between the bed rail and the therapeutic surface upon which they were laying.

Interview and documentation review identified that the resident was placed on the therapeutic surface approximately 24 hours prior to becoming entrapped.

Interview confirms that no assessment of the entrapment zones was completed for resident #238 who was identified to require the use of bed rails.

(192)

2. The licensee failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

In 2014 resident #238 had their mattress replaced with a therapeutic surface.

Documentation review identified that resident #238 was found trapped between the therapeutic surface and the half bed rail.

Observation and interview confirm that in 2014 the resident remains on the therapeutic surface with bed rails in place.

In 2014, bed pads designed for full rails were folded and applied to the bed between the half rails and the therapeutic surface without having assessed the resident's entrapment risk.

Steps to prevent further entrapment had not been initiated. (192)

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

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

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

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. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall protect resident #245 and all other residents of the home from abuse by anyone.

Grounds / Motifs :

1. The licensee of the long term care home did not protect residents from abuse by anyone.

In 2014, resident #245 was observed to be in need of assistance from staff. A Personal Support Worker (PSW) encouraged the resident to come with her while assisting another resident to their room however, the resident refused and kept walking. The PSW alerted another staff member to assist the resident. A few minutes later, the inspector overheard staff stating to the resident "no, she's trying to help you". A short time later, staff were observed with the resident. The resident had received assistance. Staff attempted to get the resident to lay down however, the resident exited their room within a few minutes. The resident walked by staff and stated "now leave me alone".

Interview with the PSW confirmed that the resident was provided assistance. It was reported that the resident was kicking and scratching at staff during the process and staff stated that they forced the resident to sit by using their hands to hold the residents hands down while they provided care. The second PSW confirmed that there were three staff members present during the process however, staff stated that the third PSW left because it was too much for the resident who may have thought they were being attacked. Documentation in the clinical record by the RPN indicated the resident was observed to have been injured.

The resident was observed in January 2014 to have sustained an injury.

Resident #245 was not protected from abuse. [s. 19. (1)] (165)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 07, 2014

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Order / Ordre :

The licensee shall review the policy to promote zero tolerance of abuse and neglect of residents and ensure that, at a minimum the policy includes the items (a) to (h) of this regulation and specifically:

(a) shall provide that abuse and neglect are not to be tolerated;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations.

Grounds / Motifs :

1. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents does not provide that abuse and neglect are not to be tolerated, contains an explanation of the duty under section 24 of the Act to make mandatory reports; set out the consequences for those who abuse or neglect residents and comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations.

The home's Policy related to "Resident Abuse" Section A, Page 1.0 dated as revised January 1, 2013 and signed December 7, 2014 was reviewed.

Interview with the Administrator and Director of Care confirm that this is the most current Abuse Policy and that the policy is not inclusive of all components required in the regulations.

The Policy does not clearly state that abuse and neglect are not tolerated, does not contain an explanation of the duty under section 24 of the Act to make mandatory reports; or set out the consequences for those who abuse or neglect residents.

In addition items referred to in O.Reg 97/10 s.96 related to the policy to promote zero tolerance of abuse and neglect, s.97 related to notification of incidents, s.98 related to police notification and s.99 related to evaluation are not included in the homes Resident Abuse policy.
(192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 14, 2014

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee shall report all incidents that required reporting via the Critical Incident System, as identified in the Regulations, that have occurred within the home between January 1, 2014 and January 16, 2014 and have not yet been reported using the Critical Incident System.

The license shall prepare a summary report of all reportable incidents occurring in 2012 and 2013, as identified in the homes Risk Reporting System and Complaint Binder, that have not previously been reported through the Critical Incident System. The report will include:
1) the date and type of incident
2) the identified risk to the resident
3) the date the incident was investigated and who was responsible for the investigation
4) the outcome of the investigation.

Where incidents have occurred as a result of repeat responsive behaviours, the report will include how residents of the home were protected.

The report is to be submitted electronically to Debora Saville, Long Term Care Homes Inspector of the Ministry of Health and Long Term Care, London Service Area Office at debora.saville@ontario.ca by ~~February~~ March 14, 2014.

Grounds / Motifs :

1. The licensee failed to immediately report the suspicion and the information upon which it as based to the Director related abuse of a resident by anyone or neglect of a resident by a licensee or staff that resulted in harm or risk of harm.

A review of homes Risk Reporting System and Complaint binder identified that at least twenty incidents of abuse had occurred in the home in 2012 and 2013.

Review of the Critical Incident System and interview with the Administrator and Director of Care confirmed that the incidents identified in the Risk Report System and Complaint binder were not reported to the Director. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : ~~Feb~~ March 14, 2014

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Order / Ordre :

The licensee shall ensure that all staff receive training related to the prevention of abuse and neglect, and the duty under section 24 to make mandatory reports.

Grounds / Motifs :

1. The licensee did not ensure that the persons who have received training under subsection (2) received retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.
Review of the home's education records revealed that all staff at the home did not receive retraining in the long term care home's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 24 to make mandatory reports. The Administrator confirmed that approximately only 14% of the home's staff received training in 2013. (165)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 28, 2014

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that the home's Critical Incident/Mandatory Reporting is reviewed and updated to reflect the reporting requirements specified in the legislation and shall ensure that the policy is complied with.

Grounds / Motifs :

1. Previously issued July 18, 2012 as a VPC

The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with.

The home's policy titled "Critical Incident/Mandatory Reporting" Section 12, Page (b) dated as revised September 2013 and signed December 3, 2013 was reviewed.
The home's policy indicated that an emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding is identified as requiring reporting within one business day rather than the required immediate reporting for an emergency including fire, unplanned evacuation or intake of evacuees.

The home's policy indicated that a resident who is missing for less than 3 hours and who returns to the home with an injury or any adverse change in condition should be reported within one business day. The legislation on reporting requires that a resident missing for less than 3 hours and who returns with no injury or adverse change in condition is reported within one business day.

The policy related to "Critical Incident/Mandatory Reporting" as noted above was not complied with.

A review of the home's Risk Management System identified that incidents of abuse and neglect as well as resident elopement for periods of less than three hours were not reported to the Director as outlined in the homes policy. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2014

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

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that where bed rails are used, the resident (including any residents on a therapeutic surface) is assessed and his or her bed system evaluated in accordance with evidence-based practices.

Grounds / Motifs :

1. The licensee of a long-term care home failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Interview with the Administrator and the Maintenance Manager identified that where bed rails were used, residents of this home were not assessed and their bed system was not evaluated.

Administrator confirmed that the home did not have a policy to direct staff in completing resident assessments and bed system evaluations.

Resident #238 was found trapped between the therapeutic surface and the half bed rail in 2014. The resident and their bed system had not been evaluated to minimize risk to the resident.
(532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2014

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

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that medication and treatment carts are secure and locked at all times.

The plan shall be submitted electronically to Debora Saville, Long Term Care Homes Inspector for the Ministry of Health and Long Term Care, London Service Area Office, 130 Dufferin Avenue, 4th Floor, London, Ontario, N6A 5R2 at debora.saville@ontario.ca

The plan is to be submitted by February 14, 2014.

Grounds / Motifs :

1. Previously issued July 18, 2012 as a VPC

The licensee failed to ensure that drugs are stored in an area or a medication cart, ii. that is secure and locked.

The medication cart was observed to be unlocked on two different occasions:
i) On January 10, 2014 at 1155 hours when a Registered Practical Nurse (RPN) was observed to give medication to a resident in their room. The RPN was observed to have left the med cart unlocked and unattended.
2) On January 10, 2014 at 1705 hours on second floor in the corridor by room 227, observation revealed that the evening RPN left medications on top of the medication cart. The RPN was in the room with the resident, the medication cart was left unattended and unlocked and accessible to passers by in the corridor.

The policy "Medication and Treatment Cart Protocol", Section M, page 0.0 indicates that the medication cart and treatment cart are to be locked at all times when not in the locked medication room.
(532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2014

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

Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee shall ensure that resident #401 is offered a minimum of three meals daily.

Grounds / Motifs :

1. The licensee did not ensure that each resident was offered a minimum of three meals daily.

Resident #401 was observed sleeping during the lunch meal in 2014. A lunch meal was plated for the resident at approximately 1218 hours. At approximately 1310 hours, the Personal Support Worker was observed throwing the lunch meal out despite the resident being observed to be awake at this time.

The Personal Support Worker reported that the resident had refused to come to the dining room however, it was too late to provide the lunch tray to the resident because it had sat out too long. The Personal Support Worker confirmed that the resident was not offered a lunch tray prior to throwing the meal out and that the resident would get a snack at 1400 hours.

At approximately 1430 hours the resident was observed finishing cookies and a family member commented that the resident must have been hungry as they ate the snack quickly.

Review of the resident's clinical health record revealed that the resident has lost weight in the past ten months. (165)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 07, 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.

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

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 7th day of January, 2014

Signature of Inspector / Signature de l'inspecteur : Debora Saville (192)

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

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