Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 31, Sep 4, 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 2012	2012_041103_0038	Resident Quality Inspection

Licensee/Titulaire de permis

COUNTY OF PRINCE EDWARD
603 Highway 49, R R 2, PICTON, ON, K0K-2T0

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

H.J. MCFARLAND MEMORIAL HOME
R.R. #2, 603 HIGHWAY 49, HALLOWELL TOWNSHIP, PICTON, ON, K0K-2T0

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

DARLENE MURPHY (103), JESSICA PATTISON (197), LYNDA HAMILTON (124), PAUL MILLER (143)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

During the course of the inspection, the inspector(s) spoke with Residents, family members, Resident and Family Council Presidents, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support workers (PSW), RAI Coordinator, the Registered Dietitian, the Nutritional/Environmental Manager, dietary aides, maintenance staff, Director of Resident Services, activity aides, physiotherapy aides, housekeeping staff, the Financial Officer, the Secretary, the Director of Resident Care and the Administrator.

During the course of the inspection, the inspector(s) conducted a walkthrough of the home, reviewed resident health care records and resident/family council meeting minutes, observed dining service, medication pass, resident care and activities, reviewed the home's staffing plan and menus; reviewed policies related to abuse, infection control, restraints, medication management, nutritional care, skin and wound care and continuous quality improvement. This inspection also included the review of three critical incidents with the following log numbers: O-000870-12, O-001953-12, O-001954-12.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following subsections:

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).

Findings/Faits saillants :

1. The following findings indicate the licensee has failed to comply with O. Reg 79/10 s. 15 (1).

On September 13, 2012, an observation of all resident beds and bed rails was conducted to follow up on order #901 issued on September 12, 2012 related to potential resident entrapment. During this observation, Residents #11 and #37 were observed to have beds that posed a Zone 7 entrapment risk as per the Health Canada's Guidance Document titled, "Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards." Zone 7 is the space between the inside surface of the headboard or footboard and the end of the mattress. This space may present a risk of head entrapment when taking into account the mattress compressibility and any shift of the mattress. Both beds were observed to have increased space in Zone 7 as a result of the ability to easily shift the mattress within the bed frame.
It was reported by Staff #120 that the mattress keeper rods for Resident # 11 and # 37 beds (Carroll bed model #CS7) were not installed as per the manufacturer's specifications and as a result this created a gap space posing an entrapment risk.

Additional Required Actions:

CO # - 901, 902 were served on the licensee. CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

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).

Findings/Faits saillants :

1. The following findings indicate that the licensee did not comply with r. 8(1)(b) in that they did not ensure that their system to monitor food and fluid intake of residents was complied with.

O. Reg 79/10, s. 68(2)(d) states that the licensee shall ensure that the nutrition and hydration program includes a system to monitor and evaluate the food and fluid intake of residents with identified risks.

During an interview with the Nutritional Manager on September 18, 2012 she stated that the expectation is for each PSW to document the food/fluid/supplement intake of their assigned residents in Point of Care (POC). She further stated that Med Plus 2.0 is given and documented on the electronic medication administration record (EMAR) by the nursing staff, however, other supplements such as Instant Breakfast should be documented by PSW's under the Nutrition - Food Supplement task in POC. She stated that supplements should not be documented under the Nutrition - Fluids task in POC because there would be no way to differentiate the supplement from regular fluids. The Nutrition Manger stated that their policy called Food and Fluid Documentation dated February 2009 does not reflect current documentation procedures and needs to be updated.

Resident #40 is assessed at moderate nutritional risk, is noted to be at risk for fluid output exceeding intake and has an order for Instant Breakfast three times daily after meals. His/Her current plan of care states to monitor intake to ensure at least 75% of meal taken.

Resident #25 is noted as having a low body mass index and has had a gradual weight loss. Part of his/her dietary goal is to avoid weight loss.

Resident #2 is identified as often having poor food/fluid intake, will often refuse meals and has recently had a significant weight loss.

Resident #4 has recently had a significant weight loss and is noted to be followed monthly Resident # 4 has recently had a significant weight loss and is noted to be followed monthly by the Registered Dietitian.

Food/fluid/supplement intake documentation was reviewed for the period of September 1-17, 2012 and the following was found:
- For resident #40 , 9 out of 17 days of fluid intakes, 0 out of 51 meal intakes and 0 out of 51 supplement intakes were not documented.
- For resident # 25, 16 out of 51 meal intakes were not documented.
- For resident # 2, from September 1 - 17, 2012, 22 out of 51 food intakes were not documented.
- For resident # 4, 29 out of 51 meal intakes were not documented.

During a phone interview with the Registered Dietitian on September 18, 2012, she stated that often she has to rely on staff to recall resident intake of supplements since PSW's tend to document supplements under the Nutrition - Fluid task. She further stated that there is a section for supplements called the Nutrition - Supplement Food task but that PSW's rarely document there. She also stated that the PSW's do not always document food/fluid intakes at each meal.
2. The licensee failed to comply with O. Reg. 79/10 s. 8. (1) (b) in that the home's Pressure Ulcers Procedure, part of the home's Skin and Wound Care Program was not complied with.
The "Pressure Ulcers" Procedure stated that the pressure ulcer will be reassessed, at least weekly.
Resident #2 had a stage 3 ulcer. There was no documented assessment of Resident #2's pressure ulcer on identified dates in July and August 2012.
3. The licensee has failed to comply with O. Reg. 79/10 s. 8 (1) in that they did not comply with the safe storage of drugs as required under O. Reg. 79/10 s. 114 (2) and in addition, did not comply with the removal of expired drugs as required under O. Reg. 79/10 s. 136 (1)(a).

The Pharmacy Service Provider, Picton Clinic Pharmacy O/O/B Medical Pharmacies Group Inc., as well as all Registered staff who administer medications have failed to comply with Pharmacy Policy and Procedures, Section 6-Monitored Medications Policy 6-4 Storage of Monitored Medications: The policy states, "all monitored medications are safety stored to comply with legislative and home requirements." The procedure (1) states, " store ALL monitored medications, separate from other medications, in a locked compartment of the cart." (143) Section 6-Monitored

Medications, Policy 6-1 defines monitored medications as all narcotics, controlled and controlled-like drugs. Picton Clinic Pharmacy provides strip pouches that contain controlled medications.
It was observed on September 11th and 12th, 2012 that Residents # 6, #12, and #22 had a regular dose of Benzodiazepines in a multi-dose strip pouch. These medications are controlled substances and are required to be stored in a separate locked area within the locked medication cart. (143) (124)
On September 11, 2012, eleven vials of injectable Morphine sulphate, 15mg/ml, five vials of injectable Dilaudid, 2mg/ml, and ten Statex 10 mg tablets were observed in the emergency stock box. The emergency stock box was kept in a locked cupboard but the box itself was not locked. The controlled substances were not double locked. (124)
The licensee has failed to comply with its pharmacy policy and procedure Section 5 Handling of Medication Policy 5-1 Expiry and Dating of Medications. Procedure (2) states, "Remove any expired medications from stock and order replacement if necessary". It is also noted that Pharmacy Policy and Procedure Section 5 Handling of Medication Policy 5-4 Drug Destruction and Disposal states in Procedure 1, " Nurse to identify on an ongoing basis (suggest weekly) and medication for disposal by (completing scheduled checks for expired goods)". (143)
On September 11, 2012, it was observed that the second floor medication cart contained expired medications for Resident #6, Lactaid dated May, 2012, stock Colace July 2012 and stock Senekot dated February 2012. The licensee has failed to comply with its pharmacy policy and procedure Section 5 Handling of Medication Policy 5-1 Expiry and Dating of Medications. Procedure (2) states, "Remove any expired medications from stock and order replacement if necessary". It is also noted that Pharmacy Policy and Procedure Section 5 Handling of Medication Policy 5-4 Drug Destruction and Disposal states in Procedure 1, " Nurse to identify on an ongoing basis (suggest weekly) and medication for disposal by (completing scheduled checks for expired goods)". (143)
On September 11, 2012, the second floor medication cupboard was noted to contain three fleet enemas with an expiry date of February, 2012 and three boxes of Dry Eyes eye drops with expiry date of February 2012. (124)
On September 14, 2012, the first floor medication cart was noted to contain Tylenol ES expired July 2005 for Resident #41, Salbutamol inhaler expired April 2012 and nitroglycerin spray expired June 2012 for Resident #20, Latanoprost eye drops opened on July 30, 2012 with instructions to discard after six weeks for Resident #9 were still present in the resident slot, Airomir puffer expired February 2012 and Timoptic eye drops opened in February 2012 with instructions to discard after three months for Resident #42, and Salbutamol sulphate solution expired May 2012 for Resident #19. (103)

On September 12, 2012 it was observed that staff S#106 did not comply with the homes pharmacy policy and procedure, Section 3-The Medication System Policy 3-7, The Medication Pass (14) by not removing resident information from empty strip pouches prior to placing the pouches in the garbage.
On September 14, 2012 between 1015-1040 it was observed that staff S#107 had left the first floor medication cart unlocked and unattended in an unlocked nursing station. This staff did not comply with with the home's pharmacy policy and procedure, Section 3 - The Medication System Policy 3-5, The Medication Cart (1) keeping the medication cart locked at all times.

Additional Required Actions:

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

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home's system for monitoring food and fluid intake of residents with identified risks related to nutrition and hydration is complied with, to be implemented voluntarily.

WN #3: 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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA s. 6 (1)(c) in that the plan of care for identified residents does not set out clear directions to staff and others who provide direct care to the residents.
During an interview with resident #30 on September 14, 2012 he/she stated that staff are supposed to do a specified treatment first thing in the morning. At the time of the interview, 1000 hours, the resident's treatment had not yet been completed.
During an interview with the Director of Resident Care on September 17, 2012, she stated that staff are supposed to do the specified treatment before the resident gets out of bed in the morning.
During an interview with resident #14's family member on September 7, 2012 it was stated that the resident prefers to sleep in his/her clothes and in his/her recliner chair and did this at home for many years. The family member feels that the home forces resident #14 to change into pajamas and to sleep in his/her bed and feels this has made the resident unhappy.
During interviews on September 18, 2012 with S#125 and S#118, they both stated that they let the resident choose what to wear to bed and where to sleep.
Upon review of the resident's health care record, there is no direction to staff related to the resident's preference of where to sleep or how to dress at bedtime.
2. The licensee has failed to comply with LTCHA 2007, s. 6(7) in that the care set out in the plan of care was not provided to a resident as specified in the plan. Resident #34 had a fall in his/her bedroom on a specified date and as a result sustained a fracture. The resident's plan of care at the time of the fall states that the resident is at risk for falls due to attempts to self-transfer and interventions include safety equipment. The incident note written on a specified date states that the safety equipment was in disrepair at the time of the fall. During an interview with S#102, she stated that the safety equipment was not in place at the time of the resident's fall because staff knew they were broken. S#102 went on to say that they usually have spare safety equipment in the home but they did not at the time of the resident's fall.
During an interview with the Director of Resident Care on September 17, 2012, she stated that they do keep spare safety equipment in the home. She went on to say that spare safety equipment should have been put in place for resident #34 if staff knew the resident's was malfunctioning.

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 73(2)(b) in that a resident who required assistance with eating and drinking was served a meal before someone was available to provide assistance.
On September 14, 2012 the breakfast meal was observed. Two PSW's were each observed to be assisting two residents each at the beginning of the observation period and one resident (#39) was sitting with his/her meal in front of him/her unassisted. When one of the PSW's was done assisting the two residents she moved over to provide assistance to resident #39.
The most recent plan of care dated for resident #39 states that his/her eating habits have declined since his/her last assessment and requires assistance with meals.
On September 11, 2012 it was observed that a plated dinner was placed in front of an unidentified resident and staff were not available to provide assistance with the meal. (143)
2. The licensee has failed to comply with O. Reg. 79/10, s. 73(1)2 in that meal and snack times were not reviewed by the Residents' Council.
During an interview on September 14, 2012 with resident #30, he/she stated that the Residents' Council has not had a chance to review meal and snack times.
During an interview with the Nutritional Manager on September 14, 2012 she stated that it had been a few years since she last discussed meal and snack times with the Residents' Council.
3. The licensee has failed to comply with O. Reg. 79/10, s. 73(1)4 in that residents eating in locations other than dining areas are not monitored.
On September 4, 2012 resident #6 was observed to be eating his/her lunch in his/her room. At that time he/she stated that he/she had been eating in his/her room for approximately two weeks. When asked, he/she stated that staff do not check on him/her in the room during meals. This resident also does not have a call bell within reach when sitting in his/her chair to eat his/her meals.
During an interview with S#105 on September 4, 2012 she stated that because resident #6 is independent they do not check on him/her when the resident is eating meals in his/her room.
During an interview with the Director of Resident Care on September 13, 2012 she stated that her expectation is that all nursing and personal support staff working during the meal would rotate to monitor residents periodically who receive tray service in their rooms.
4. The licensee has failed to comply with O. Reg. 79/10, s. 73(1)10 in that proper techniques were not used to assist residents with eating.
On September 14, 2012 during the breakfast meal a PSW was observed to feed four residents while in the standing position.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure a process is in place to monitor all residents during meals, that proper techniques are used to assist residents who require assistance with eating and that no resident that requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following subsections:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10 s. 17. (1)(f) in that the resident-staff communication system did not clearly indicate where the signal was coming from when activated as evidenced by the following findings.
On September 5, 2012, resident #13's call bell was activated resulting in no visual or audible signal.
On September 6, 2012, resident # 27's call bell was activated resulting in no visual or audible signal.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the resident-staff communication system for all residents is functioning at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following subsections:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The following findings indicate the licensee has failed to comply with O. Reg 79/10 s. 31 (3).
On September 14, 2012 the Director of Resident Care reported that the staffing plan does not provide written direction in respect of work routines and adjustments when staff cannot come to work.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure a back-up plan that addresses staff allocation and work routines is in place when staff cannot come to work, to be implemented voluntarily.

WN #7: 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 subsections:

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).

Findings/Faits saillants :

1. The following findings indicate the licensee has failed to comply with LTCHA s. 3 (1) 11. iv.
On September 12th, 2012 it was observed that S#106 did not comply with the home's pharmacy policy and procedure, Section 3-The Medication System Policy 3-7, The Medication Pass (14) by not removing resident information from empty strip pouches prior to placing the pouches in the garbage.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following subsections:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(a) is a minimum of 21 days in duration;
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks;
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner;
(d) includes alternative beverage choices at meals and snacks;
(e) is approved by a registered dietitian who is a member of the staff of the home;
(f) is reviewed by the Residents' Council for the home; and
(g) is reviewed and updated at least annually. O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 71(1)(f) in that the home's menu cycle has not been reviewed by the Residents' Council.
During an interview on September 14, 2012 with the Nutritional Manager she stated that she has never submitted the home's menu to the Residents' Council for review. She further stated that her practice has been to post each menu before it is implemented in the auditorium for family and residents to review and provide feedback.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following subsections:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA 2007, s. 29. (1) (b) in that the home's Restraints and Safety Devices Policy was not complied with.
Resident #4 was observed on an identified date to be wearing a front closing lap belt that the resident could not undo.
Resident #4's Point of Care documentation did not identify that he/she has a lap belt as a physical restraint.
The home's Restraints and Safety Devices (non-chemical) Policy and Procedure stated that repositioning and monitoring will be documented by the Health Care Aid/Personal Support Worker.
There was no documentation of the repositioning and monitoring of Resident #4 while he/she was wearing the lap belt.

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

Specifically failed to comply with the following subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 in that a resident exhibiting altered skin integrity was not reassessed at least weekly by a member of the registered nursing staff.
Resident #2 is a resident who had a stage three ulcer.
S#102 reported to the inspector that registered staff document the weekly assessments of wounds in Point Click Care.
There is no clinical documentation to indicate that the resident's stage three ulcer had weekly assessments done.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information

Specifically failed to comply with the following subsections:

s. 225. (1) For the purposes of clause 79 (3) (q) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 79 of the Act includes the following:
1. The fundamental principle set out in section 1 of the Act.
2. The home's licence or approval, including any conditions or amendments, other than conditions that are imposed under the regulations or the conditions under subsection 101 (3) of the Act.
3. The most recent audited report provided for in clause 243 (1) (a).
4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service.
5. Together with the explanation required under clause 79 (3) (d) of the Act, the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act. O. Reg. 79/10, s. 225 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10 s. 225. (1)3 in that the most recent audited report was not posted in the home.
The Administrator confirmed that the home did not have the most recent audited report posted.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following subsections:

s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;
(c) that the local medical officer of health is invited to the meetings;
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

s. 229. (12) The licensee shall ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunizations. O. Reg. 79/10, s. 229 (12).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 229. (10) in that there is not a staff immunization program in place for diphtheria or tetanus.
The Director of Resident Care reported that there is no program in place for staff immunizations for diphtheria/tetanus.
2. The licensee failed to comply with O. Reg. 79/10 s. 229. (10) 3. in that not all residents are offered immunizations against pneumococcus, tetanus and diphtheria in accordance with publicly funded immunization schedules posted on the Ministry website.
There is no clinical documentation to confirm that Residents #16, #17, #18 or #15 have received immunization for pneumococcus, diphtheria or tetanus.
The Director of Resident Care confirmed that the home did not have a policy in place for residents to be offered immunization for diphtheria or tetanus.
3. The licensee failed to comply with O.Reg. 79/10 s. 229. (10) 1. in that each resident admitted to the home was not screened for tuberculosis within 14 days of admission as demonstrated by the following findings.
There is no clinical documentation to confirm that Resident #16, and Resident #17, have been screened for tuberculosis within 14 days of admission.
4. The licensee failed to comply with O. Reg. 79/10 s. 229. (2) (b) in that the Infection Prevention and Control interdisciplinary team did not meet at least quarterly.
On September 13, 2012, the Director of Resident Care reported that the home's infection control committee had only one meeting thus far in 2012.
5. The licensee failed to comply with O. Reg. 229. (12).
On September 14, 2012, the Director of Resident Services could not confirm if the pets visiting as part of the pet visitation program had up to date immunization; she had no records of their immunization.
6. The licensee failed to comply with O. Reg. 79/10 s. 229. (10) 4. in that staff are not screened for tuberculosis.
The Director of Resident Care and the Administrator reported to the inspector that currently there is no program in place to screen staff for tuberculosis.
7. The licensee has failed to comply with O. Reg. 79/10, s. 229. (10).
The Director of Resident Services reported to the inspector that there is no program in place for staff immunizations for diphtheria/tetanus.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure staff are immunized in accordance with evidence based practices and residents are offered immunizations in accordance with the publicly funded immunization schedule posted on the Ministry website, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 26(3)10 in that the plan of care was not based on an interdisciplinary assessment of a resident's risk of falls.
The health care record for resident #34, including the most recent plan of care was reviewed on September 11, 2012. There was no evidence of an assessment related to the use of a piece of equipment to prevent falls and interviews with S#102 and S#114 confirmed that there was no assessment done related to the use of this equipment or the risks related to it's use for the resident.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following subsections:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The following findings indicate the licensee has failed to comply with O. Reg 79/10 s. 37 (1).
On September 5, 2012, unlabelled personal items including combs, toothbrushes, and hairbrushes were found in the Willow wing tub room. On September 6, 2012, Resident #3's shared bathroom contained plastic storage bins with unlabelled personal care items.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

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).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10 s. 129. (1)(a) in that drugs are not stored in an area or medication cart that is used exclusively for drugs and drug related supplies as demonstrated by the following finding.
On September 11, 2012 it was observed that the second floor medication cart had four quarters stored in a resident medication bin.
2. On September 11, 2012, the locked drug storage cupboard on the second floor that contained stock medication also contained Resident #25's hearing aid batteries and hearing aid case.
3. The first floor medication cart contained a watch in Resident #19's medication slot and 2 pairs of unidentified resident glasses in baggies.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The following findings indicate the licensee has failed to comply with O. Regs s. 130. 2.
On September 11, 2012 on or about 1400 hours, the housekeeper was found alone in the first floor medication room vacuuming the floor. The door to the medication room was open and there was no registered staff in attendance at the time.
2. On September 14, 2012 from 1015 to 1040 the first floor medication cart was not locked when in use and the nursing station door was open.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following subsections:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The following findings indicate the licensee failed to comply with O. Reg 79/10 s. 97 (2).
It was reported on an identified date that resident #5 was allegedly verbally abused by a staff member. The Substitute Decision Maker was not notified of the results of the alleged abuse investigation.
The home submitted a critical incident report #M556-000013-12 to report an alleged staff to resident abuse. The home failed to notify the family members of the results of the investigation into the alleged abuse immediately upon the completion of the investigation.(103)
2. The following findings indicate the licensee failed to comply with O. Regs s. 97 (1) (b).
The Director of Resident Care was interviewed and could recall notifying the family members of the alleged abuse, but could not recall if the notification was within twelve hours of becoming aware of the alleged abuse. There was no documentation to indicate the time of the notifications.
On an identified date, a Personal Support Worker allegedly verbally abused a resident. The Substitute Decision Maker was not notified within 12 hours upon becoming aware of the alleged, suspected or witnessed incident of abuse. (143)

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The following findings indicate the licensee has failed to comply with O. Reg 79/10 s. 99 (b).
On September 17, 2012, the Director of Resident Care reported that home has not completed an annual evaluation of the abuse policy and any changes and improvements required to prevent further occurrences.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following subsections:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The following findings indicate the licensee has failed to comply with O. Reg. 79/10 s. 104 (1) 2 and s. 104 (1) 4. The home submitted a critical incident report # M556-000013-12 to report an alleged staff to resident abuse. The report failed to include the staff name of the alleged abuser.
2. Under the heading of immediate actions taken to prevent recurrence, the licensee stated the investigation has just been initiated. The licensee failed to include any immediate actions to prevent recurrence of the alleged abuse.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 s. 110 (7) in that there was no documentation of every release of the device and repositioning.
Resident #4's Point of Care documentation does not identify that he/she has a lap belt as a physical restraint.
There was no documentation regarding every release of his/her lap belt or the repositioning of Resident #4 while he/she was wearing the lap belt.
2. The licensee failed to comply with O.Reg. 79/10, s.110. (7) 6. in that the documentation did not include the monitoring of the resident including the resident's response.
Resident #4's lap belt restraint was not identified in Point of Care and therefore there was no documentation of the monitoring of Resident #4 while he/she was wearing the lap belt or of his/her response.
3. The licensee failed to comply with O.Reg. 79/10 s. 110 (7) 5. in that there was no documentation of the person who applied the device and the time of application.
Resident #4 was observed to be wearing a front closing lap belt that the resident could not undo. Resident #4's Point of Care documentation does not identify that he/she has a lap belt as a physical restraint. There is no documentation regarding the person who applied the lap belt and the time of application of the lap belt.

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee has failed to comply with s. 85(4)(a) in that the licensee did not make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.
During an interview with resident #30 he/she stated that he/she does not recall receiving the results of the satisfaction survey that was done in the Fall of 2011.
On September 14, 2012 the Residents' Council meeting minutes were reviewed back to Fall 2011. The January 2012 meeting minutes stated that the results of the 2011 satisfaction survey would be discussed by the Administrator at a future meeting. Meeting minutes from February 2012 to present were reviewed and there was no evidence that the satisfaction survey results were given.
During an interview with the Residents' Council Assistant, S#122, he/she stated that he/she could not recall the results of the 2011 satisfaction survey being discussed with the Residents' Council.

WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following subsections:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) an explanation of the duty under section 24 to make mandatory reports;
(e) the long-term care home's procedure for initiating complaints to the licensee;
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints;
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained;
(h) the name and telephone number of the licensee;
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home;
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home;
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges;
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge;
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs;
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents;
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package;
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations;
(q) an explanation of the protections afforded by section 26; and
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA 2007, s. 78. (2) (c) in that the home's admission package does not include the home's policy to promote zero tolerance of abuse and neglect of residents.
The "Resident Family Orientation Guide" includes a section entitled "Zero Tolerance for Resident Abuse Policy". Information regarding the procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents and the consequences for those who abuse or neglect residents was not part of the "Zero Tolerance for Resident Abuse Policy" included in the admission package and is required under the LTCHA 2007, s. 20. (2).
2. The licensee failed to comply with LTCHA 2007, s. 78. (2) (h).
On September 11, 2012, the Administrator reported to the inspector that the name and telephone number of the licensee is not included in the admission package.

WN #23: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA 2007, s. 79. (3) (c) in that the home's policy to promote zero tolerance of abuse and neglect of residents was not posted and communicated.
The "Zero Tolerance for Resident Abuse Policy" was posted and did not contain information regarding the procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents and the consequences for those who abuse or neglect residents. This information is a required part of the home's abuse policy as per the LTCHA 2007, s. 20. (2).
2. The licensee failed to comply with the LTCHA 2007, s. 79. (3) (h).
On September 11, 2012, the Administrator reported to the inspector that the name and telephone number of the licensee was not posted and communicated.

WN #24: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The following findings indicate the licensee has failed to comply with LTCHA s. 15 (2) (a).
It was observed on September 5, 2012 that two chairs in the Lilac Unit, a burgundy wing chair and a green lazy boy chair, had visible stains on them. On September 18, 2012 at approximately 1145 hours, staff #113 reported to the inspector that as part of daily cleaning and when additional staff are provided more thorough cleaning is completed such as cleaning furniture. Staff #113 was interviewed about stains on chairs in lounge if they were permanent or had the ability to be cleaned. It was observed on September 18, 2012, at 1415 hours that the chairs had been cleaned and the stains were removed. Stains on the chairs were present from September 5-18, 2012 and had not been cleaned as required.

WN #25: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

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).

Findings/Faits saillants :

1. The following findings indicate the licensee has failed to comply with LTCHA s. 20 (2).
A review of the home's abuse policy and procedure revealed that it did not contain an explanation of the duty under section 24 of the Act to make mandatory reports.

WN #26: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following subsections:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 57(2) in that the licensee does not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.
On September 14, 2012 during an interview with resident #30, he/she stated that the Residents' Council does not receive a written response to their concerns from the home.
On September 17, 2012 the Residents' Council meeting minutes for the last few months were reviewed. There are resident concerns noted in the minutes, but there is no evidence of a written response from the home within 10 days.
During an interview with the Administrator of the home on September 14, 2012 she stated that she usually responds verbally to the Residents' Council within the week or if a meeting is close she will wait and asked to be invited to the meeting so she can address the concern at that time. When asked about providing a response in writing she stated that her response is captured in the minutes if she attends, but that she has not written a formal response to the Residents' Council.

WN #27: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following subsections:

s. 59. (4) When a Family Council is established, the licensee shall notify the Director or anyone else provided for in the regulations of the fact within 30 days of the establishment. 2007, c. 8, s. 59. (4).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007 s. 59(4) in that the Family Council was formed in February 2012 and during an interview with the Administrator on Sept 14, 2012 she stated that she has not yet notified the Director of the establishment of the Family Council in the home.

WN #28: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA s. 60 (2) in that the licensee did not respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.
The June 2012 Family Council meeting minutes raise concerns related to inconsistent air temperatures, the use of the auditorium for staff training and the phone system. The July 2012 minutes state that the Administrator discussed all of these issues at the meeting, but there is no response in writing or evidence that a response what given before the meeting.
During an interview with the Administrator on September 14, 2012 she confirmed that she had not yet responded to Family Council concerns in writing.

Issued on this 21st day of September, 2012

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARLENE MURPHY (103), JESSICA PATTISON (197), LYNDA HAMILTON (124), PAUL MILLER (143)
Inspection No. / No de l'inspection :	2012_041103_0038
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Date of Inspection / Date de l'inspection :	Aug 31, Sep 4, 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 2012
Licensee / Titulaire de permis :	COUNTY OF PRINCE EDWARD 603 Highway 49, R R 2, PICTON, ON, K0K-2T0
LTC Home / Foyer de SLD :	H.J. MCFARLAND MEMORIAL HOME R.R. #2, 603 HIGHWAY 49, HALLOWELL TOWNSHIP, PICTON, ON, K0K-2T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BETH PIPER

To COUNTY OF PRINCE EDWARD, 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. 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 all residents who utilize bed rails are audited and assessed for entrapment risk.

All appropriate steps shall be immediately taken to mitigate any risks to residents where beds and bed rails do not meet the requirements as identified within Health Canada's Guidance Document titled "Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards", including taking steps to prevent resident entrapment.

In instances where resident bed rails are removed as a result of not meeting the above requirements, the resident will be assessed to ensure other safety issues are addressed.

Grounds / Motifs :

1. The following findings indicate the licensee has failed to comply with Ont. Regs s. 15 (1).

Resident #34 is cognitively impaired and has sustained a fracture as a result of a fall. The progress notes were reviewed and indicate the resident has been found on more than one occasion with his/her legs hanging over the side of the bed and required repositioning by staff.

On identified dates, the resident was observed to have a piece of fall prevention equipment with an opening that posed a potential entrapment risk.

The resident health care record was reviewed and there was no evidence the resident received an assessment related to the risks of using this piece of fall prevention equipment.

Registered staff and the Administrator were interviewed and were unable to identify how the piece of equipment came into place. (197)

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) (b)

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 prepare, submit and implement a plan for achieving compliance with O. Reg 79/10, s. 15 (1). The plan shall include:
- strategies that will be used to reduce or eliminate the risk of resident entrapment including documented assessments.
- education for all nursing and maintenance staff regarding the interventions adopted by the home to minimize or eliminate the risk of resident entrapment.
-the process for ongoing monitoring to ensure sustained compliance.

The plan shall be submitted on or before September 20, 2012 to Inspector, Darlene Murphy by mail at 347 Preston St., 4th floor, Ottawa, Ontario, K1S 3J4 or by fax at 613-569-9670.

Grounds / Motifs :

1. The following findings indicate the licensee has failed to comply with O. Regs. 79/10 s. 15 (1).

On September 13, 2012, an observation of all resident beds and bed rails was conducted to follow up on order #901 issued on September 12, 2012 related to potential resident entrapment.

During this observation, Residents #11 and #37 were observed to have beds that posed a Zone 7 entrapment risk as per the Health Canada's Guidance Document tilted, "Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards."

Zone 7 is the space between the inside surface of the headboard or footboard and the end of the mattress. This space may present a risk of head entrapment when taking into account the mattress compressibility and any shift of the mattress.

Both beds were observed to have increased space in Zone 7 as a result of the ability to easily shift the mattress within the bed frame.

It was reported by Staff # 120 that the mattress keeper rods for Resident # 11 and # 37 beds (Carroll bed model #CS7) were not installed as per the manufacturer's specifications and as a result this created a gap space posing an entrapment risk. (143) (197)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 30, 2012

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) (b)

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 prepare, submit and implement a plan for achieving compliance with LTCHA s. 8 (1) (b) through the following actions:

-together with the Picton Clinic Pharmacy, develop a process to ensure that all 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.
-develop medication policies related to the safe storage of controlled substances which are in accordance with all applicable requirements under the Act.
-ensure all medications in medication storage carts, emergency stock boxes, medication storage areas including medication storage fridges are reviewed and have all expired medications removed.
-ongoing monitoring of the process for the removal of expired medications to ensure continued compliance.
-provide education to all registered nursing staff in regards to the home's policies related to medication management system.

This plan shall be submitted in writing by October 2, 2012 to Inspector, Darlene Murphy by mail at 347 Preston St., 4th floor, Ottawa, ON, K1S 3J4 or by fax at, 613-569-9670.

Grounds / Motifs :

1. The licensee has failed to comply with O. Regs 79/10 s. 8 (1) in that they did not comply with the safe storage of drugs as required under O. Regs. 79/10 s. 114 (2) and in addition, did not comply with the removal of expired drugs as required under O. Regs. 79/10 s. 136 (1) (a).

The Pharmacy Service Provider, Picton Clinic Pharmacy O/O/B Medical Pharmacies Group Inc., as well as all Registered staff who administer medications have failed to comply with Pharmacy Policy and Procedures, Section 6-Monitored Medications Policy 6-4 Storage of Monitored Medications:
The policy states, "all monitored medications are safety stored to comply with legislative and home requirements."
The procedure (1) states, " store ALL monitored medications, separate from other medications, in a locked compartment of the cart." (143)
Section 6-Monitored Medications, Policy 6-1 defines monitored medications as all narcotics, controlled and controlled-like drugs.

Picton Clinic Pharmacy provides strip pouches that contain controlled medications. It was observed on an identified date that Resident # 6, #12 and #22 had regular doses of benzodiazes within a multi-dose strip pouches, These medications are controlled substances and are required to be stored in a separate locked area within the locked medication cart. (143) (124)

On September 11, 2012, eleven vials of injectable Morphine sulphate, 15mg/ml, five vials of injectable Dilaudid, 2mg/ml, and ten Statex 10 mg tablets were observed in the emergency stock box. The emergency stock box was kept in a locked cupboard but the box itself was not locked. The controlled substances were not double locked. (124)

The licensee has failed to comply with its pharmacy policy and procedure Section 5 Handling of Medication Policy 5-1 Expiry and Dating of Medications. Procedure (2) states, "Remove any expired medications from stock and order replacement if necessary". It is also noted that Pharmacy Policy and Procedure Section 5 Handling of Medication Policy 5-4 Drug Destruction and Disposal states in Procedure 1, " Nurse to identify on an ongoing basis (suggest weekly) and medication for disposal by (completing scheduled checks for expired goods)". (143)

On September 11, 2012, it was observed that the second floor medication cart contained expired medications for Resident #6, Lactaid dated May, 2012, stock Colace July 2012 and stock Senekot dated February 2012. The licensee has failed to comply with its pharmacy policy and procedure Section 5 Handling of Medication Policy 5-1 Expiry and Dating of Medications. Procedure (2) states, "Remove any expired medications from stock and order replacement if necessary". It is also noted that Pharmacy Policy and Procedure Section 5 Handling of Medication Policy 5-4 Drug Destruction and Disposal states in Procedure 1, " Nurse to identify on an ongoing basis (suggest weekly) and medication for disposal by (completing scheduled checks for expired goods)". (143)

On September 11, 2012, the second floor medication cupboard was noted to contain three fleet enemas with an expiry date of February, 2012 and three boxes of Dry Eyes eye drops with expiry date of February 2012. (124)

On September 14, 2012, the first floor medication cart was noted to contain Tylenol ES expired July 2005 for Resident #41, Salbutamol inhaler expired April 2012 and nitroglycerin spray expired June 2012 for Resident #20, Latanoprost eye drops opened on July 30, 2012 with instructions to discard after six weeks for Resident #9 were still present in the resident slot, Airomir puffer expired February 2012 and Timoptic eye drops opened in February 2012 with instructions to discard after three months for Resident #42, and Salbutamol sulphate solution expired May 2012 for Resident #19. (103) (143)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 29, 2012

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. 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).

Order / Ordre :

The licensee shall ensure that fall strategies and interventions are in place for all residents identified at risk of falls as specified in the plan of care and that a process is in place to ensure that equipment such safety alarms are replaced promptly when identified to be in disrepair.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA 2007, s. 6(7) in that the care set out in the plan of care was not provided to a resident as specified in the plan.
Resident # 34 had a fall in his/her bedroom on an identified date and as a result sustained a fracture.
The resident's plan of care at the time of the fall states that the resident is at risk for falls due to attempts to self-transfer and interventions include the use safety equipment.
The incident note written on an identified date states that the safety equipment were in disrepair at the time of the fall.
During an interview with S#102, she stated that the safety equipment were not in place at the time of the resident's fall because staff knew they were malfunctioning. S#102 went on to say that they usually have spare safety equipment in the home but they did not at the time of the resident's fall.
During an interview with the Director of Resident Care on September 17, 2012, she stated that they do keep spare safety equipment in the home. She went on to say that spare safety equipment should have been put in place for resident # 34 if staff knew the resident's was broken. (197)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 02, 2012

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 prepare, submit and implement a plan for achieving compliance with O. Reg 79/10, s. 15 (1). The plan shall include:
-strategies that will be used to reduce or eliminate the risk of resident entrapment including documented assessments.
-education for all nursing and maintenance staff regarding the interventions adopted by the home to minimize or eliminate the risk of resident entrapment.
-the process for ongoing monitoring to ensure sustained compliance.

The plan shall be submitted on or before September 20, 2012 to Inspector, Darlene Murphy by mail at 347 Preston St., 4th floor, Ottawa, Ontario K1S 3J4 or by fax at 613-569-9670.

Grounds / Motifs :

1. The following findings indicate the licensee has failed to comply with O. Regs 79/10 s. 15 (1).

On September 13, 2012, an observation of all resident beds and bed rails was conducted to follow up on order #901 issued on September 12, 2012 related to potential resident entrapment.

During this observation, Residents #11 and #37 were observed to have beds that posed a Zone 7 entrapment risk as per the Health Canada's Guidance Document titled, "Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards."

Zone 7 is the space between the inside surface of the headboard or footboard and the end of the mattress. This space may present a risk of head entrapment when taking into account the mattress compressibility and any shift of the mattress.

Both beds were observed to have increased space in Zone 7 as a result of the ability to easily shift the mattress within the bed frame. (197)
2. It was reported by Staff #120 that the mattress keeper rods for Resident # 11 and # 37 beds (Carroll bed model #CS7) were not installed as per the manufacturer's specifications and as a result this created a gap space posing an entrapment risk. (143)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 30, 2012

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 Clerk
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

the day of mailing and when service is made by fax, it is
e is not served with written notice of the Director's decision
) deemed to be confirmed by the Director and the Licensee is
riod.

n Inspector's Order(s) to the Health Services Appeal and
Act, 2007. The HSARB is an independent tribunal not
erning 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

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

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

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

Ministère 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

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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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 21st day of September, 2012

Signature of Inspector / Signature de l'inspecteur : Darlene Murphy

Name of Inspector / Nom de l'inspecteur : DARLENE MURPHY

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