Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 12, 2012	2012_024137_0053	L-001149-12	Resident Quality Inspection

Licensee/Titulaire de permis

MEADOW PARK (LONDON) INC
689 YONGE STREET, MIDLAND, ON, L4R-2E1

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

MEADOW PARK (LONDON) INC.
1210 SOUTHDALE ROAD EAST, LONDON, ON, N6E-1B4

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

MARIAN MACDONALD (137), CAROLEE MILLINER (144), RUTH HILDEBRAND (128), SHARON PERRY (155)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 17-19, October 22-26, October 29-31, November 1-2 and November 5-6, 2012.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care,(DOC) Co-Director of Care, (Co-DOC) Resident and Family Services Coordinator, Food Service Supervisor, (FSS) Environmental Services Supervisor,(ESS) Office Manager, Physiotherapist, Physiotherapy Assistant, Kinesiologist, Advisory Physician, Consultant Pharmacist, Care Services Coordinator (Corporate), Life Enrichment Coordinator, Staff Educator, RAI Coordinator, Volunteer Coordinator, Restorative Care Coordinator, Staffing Coordinator, Family Council President, Residents' Council President, 8 Family Members, 40+ Residents, 2 Laundry Aides, 3 Dietary Aides, 3 Housekeeping Aides, 1 Maintenance Person (contract), 2 Activity Aides, 4 Registered Nurses, (RN) 9 Registered Practical Nurses (RPN) and 29 Health Care Aides/Personal Support Workers.(HCA/PSW)

During the course of the inspection, the inspector(s) toured all resident home areas, medication rooms, laundry room, kitchen and linen storage areas, observed resident care, staff/resident interactions, dining and snack service, medication administration, recreational activities, reviewed relevant policies and procedures, posting of required information, reviewed relevant residents' clinical records, resident charges records and minutes of meetings related to the inspection.
L-001149-12.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Death
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
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
Snack Observation
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. Two written notifications of non-compliance and two voluntary plans of correction have previously been issued on September 13, 2011.

Clear direction has not been provided to staff related to the written plan of care for an identified resident. The Master diet list by table number states that the resident is to receive pudding at pm snack and HS snack but the diet list by room number states that the resident is to receive a sandwich.
The food service supervisor acknowledged that the lists did not match nor did they provide clear direction to staff. [s. 6. (1)]

2. An identified resident's plan of care does not indicate that the resident has lower natural teeth and that staff need to assist resident with cleaning of the teeth. Interviews, with three PSW's/HCA's, all indicated that the resident has dentures. The last head to toe assessment indicated that the resident has lower natural teeth. The DOC confirmed that the plan of care did not provide clear direction to staff regarding oral care. [s. 6. (1) (c)]

3. There is no evidence to support that staff collaborate with each other in the assessment and development and implementation of the plans of care for residents. A record review for an identified resident revealed that the diet order has not been written to provide a diet type, food texture and fluid consistency. The registered dietitian confirmed that there was confusion related to the way the diet order was written and that the dietitian would reassess the resident and re-write the diet order. The dietician also confirmed of not being consistently notified when there was a diet order change. The resident's diet order does not match the care plan nor either of the two meal and snack diet lists.
Diet lists by table number and by room number do not match the resident's diet order and care plan.
The registered dietitian confirmed that the home has had discussions but there is not a formalized process in place to ensure there is an integration of assessments and plans of care for residents. [s. 6. (4) (a)]

4. The plan of care for an identified resident indicates that the resident is to receive a 1/2 sandwich at PM and HS snack daily and that staff are to provide modified texture. The registered dietitian confirmed in an interview that her expectation was that the resident was to be receiving the interventions outlined in the plan.
Observation of the p.m. snack cart on October 25, 2012 revealed that the sandwich

outlined in the plan of care was not provided.
A registered nurse confirmed that the sandwich was not available for the resident. [s. 6. (7)]

5. Evidence of non-compliance captured in #'s 4, 8, 10, 11, 12 and 13. [s. 6. (7)]

6. Evidence of non-compliance captured in #'s 4, 8, 10, 11, 12 and 13. [s. 6. (7)]

7. Evidence of non-compliance captured in #'s 4, 8, 10, 11, 12 and 13. [s. 6. (7)]

8. The licensee has not ensured that the care set out in the plan of care was provided to an identified resident as evidenced by:
A clinical record review revealed that the care plan states that the resident is totally dependent on staff for eating and that a staff member feeds the entire meal. The resident is at high nutritional risk related to not eating.
The resident was observed trying to feed self at the lunch meal October 26, 2012 without a staff member present at the table. The resident did not consume the entrée of this meal.
Personal support workers and a registered nurse confirmed that the resident is not eating well.
The snack list attached to the afternoon snack cart, on October 26, 2012 stated that the resident was to receive High Energy, High Protein milk(HEHP) at pm snack as well as a sandwich. However, there was neither HEHP milk nor a sandwich on the snack cart for the resident.
A personal support worker stated that the sandwich was given to another resident and that the identified resident would get pudding. The PSW confirmed that the HEHP milk was not sent for the resident but the resident is usually provided juice anyway. [s. 6. (7)]

9. Evidence of non-compliance captured in #'s 4, 8, 10, 11, 12 and 13. [s. 6. (7)]

10. Plans of care were not followed, at afternoon snack, in the Oxford wing, on October 31, 2012, for the following residents as correct diets and/or interventions were not provided:
*One identified resident was not offered a sandwich as per the care plan and a sandwich was not provided on the snack cart;
*Two identified residents were offered regular juice which was not allowed on their

restricted diets;
The personal support worker delivering the snacks and beverages did not refer to the diet list on the snack cart nor the menu.
The food service supervisor acknowledged that the expectation is that staff are to follow the Master Diet List to ensure that residents receive the correct diets and that interventions are provided. [s. 6. (7)]

11. The plan of care for an identified resident revealed that the goal is for the resident to participate in 2 social programs and receive two 1 to 1 visits weekly.
A record review revealed that the resident attended 5 social events and had one 1 to 1 visit in the month of October. [s. 6. (7)]

12. The plan of care revealed that the activation goal is that an identified resident will receive 2 one to one visits per week and the resident will be taken to and from each program when not in bed (musical programs, church services).
A record review revealed that the resident had two 1 to 1 visits in the month of October and attended 6 programs. [s. 6. (7)]

13. The plan of care revealed that the activation goal was that an identified resident would receive 2 one to one visits per week.
However, record review revealed that the resident only had two 1 to 1 visits over a 25 day time frame. [s. 6. (7)]

14. The plan of care for an identified resident indicates that the resident is to receive a 1/2 sandwich provided at PM and HS snack daily. The care plan also states that staff are to provide modified texture.
Interviews with a personal support worker, a RPN and the physician confirmed that the resident's condition has been deteriorating and has not been taking anything via spoon.
The plan of care has not been reviewed and revised to reflect the resident's change of condition.
The registered dietitian confirmed in an interview that the deterioration in the resident's condition had not been communicated to the dietitian. [s. 6. (10) (b)]

15. Evidence of non-compliance captured in #'s 14 and 16. [s. 6. (10) (b)]

16. The plan of care has not been revised, for an identified resident, post

hospitalization. A clinical record review revealed the care plan states the resident is to receive a nutritional supplement yet the order was discontinued.
A registered nurse confirmed that the order had been discontinued but that was one of the few things that the resident would drink. Concern was expressed that the resident was not eating well.
The food service supervisor confirmed that the nutritional supplement was discontinued in error, after MOHLTC inspector identified this, and that the FSS had contacted the registered dietitian and the physician to get it re-ordered. [s. 6. (10) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that,
(a) there is an organized program of housekeeping for the home; 2007, c. 8, s. 15 (1).
(b) there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents; and 2007, c. 8, s. 15 (1).
(c) there is an organized program of maintenance services for the home. 2007, c. 8, s. 15 (1).

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

Findings/Faits saillants :

1. A previous written notice of non-compliance and a voluntary plan of correction were issued on May, 2, 2012, related to home, furnishings and equipment not being kept clean and sanitary.

The laundry service program does not meet the linen needs of residents as evidenced by insufficient quantities of linens available and linens observed to be stained, discoloured and in disrepair, which was revealed during staff interviews and observations by inspectors (#137 and # 155) on all home areas. [s. 15. (1) (b)]

2. During the October 17, 2012 lunch meal in the Elgin/Oxford dining room, Inspector # 155 observed dried food debris on the wall, bulletin board and wall paper, behind the soiled dish utility cart, as well as the hand rail, under the Point of Care (POC) kiosk, was not clean.
The radiator cover was missing by an identified table, exposing vertical metal pieces.
Spider webs were observed by an identified table, from the window to flower vases on the window sill.

Thirteen days later, on October 30, 2012 @ 11:10 am, in Elgin/Oxford dining room, Inspectors # 128 and # 137 observed the wall paper, wall and wooden wall guard under the menu board, the wall by two identified tables, the radiator cover and window glass by an identified table still to be soiled with dried food debris.
The ceiling air conditioner was observed to contain dust and in need of cleaning.
The radiator cover was observed to be rusted and scraped of paint.
The seat cushions of 31/37 (83.78%) dining chairs were observed to be stained and dining room table legs/pedestals were scratched.
The Administrator and Food Service Supervisor observed and confirmed the observations of the Inspectors. [s. 15. (2) (a)]

3. Inspector # 137 observed the ceiling lift bar cover in Oxford tub room to be covered with dust, on two days during the inspection.
Inspector # 128 observed a large floor fan, at end of Kent near Lambton, to be covered with strings of dust. [s. 15. (2) (a)]

4. Evidence of non-compliance captured in #'s 2, 3 and 5. [s. 15. (2) (a)]

5. Observations of the Chapel, by Inspectors # 128, 137 and 155, revealed fourteen chairs to be soiled and stained. [s. 15. (2) (a)]

6. On October 17, 2012 at noon, Inspector # 128 observed two cupboard doors in disrepair, a hole in the dining room wall and the garbage can lid was dirty, in Lambton dining room.
October 23, 2012, Inspector # 155 observed a phone outlet box lying on the floor and resident's room noted to have chipped paint off of wall at head of bed and closet door in an identified room on Elgin. Door frames to room and bathroom had paint chipped in another identified room on Elgin.

A ceiling light was observed not working in the lounge at the end of Elgin, in front of Kent.
On October 26, 2012 at 8:40 am, Inspector # 137 observed holes/damage to six identified rooms on Lambton.
On October 31, 2012 at 12 noon, Inspector # 137 observed 4 damaged and scraped ceiling tiles in Lambton tub room, as well as damaged floor tiles and chipped wall in Oxford elevator.
[LTCHA, 2007 S.O. 2007, c.8, s.15(2)(c)] [s. 15. (2) (c)]

7. Evidence of non-compliance captured in #'s 6, 8 and 9. [s. 15. (2) (c)]

8. The Chapel walls were damaged, baseboard lifted and had rust stains on the floor. [s. 15. (2) (c)]

9. Observations of the servery area in the main dining room revealed the following maintenance issues:
- the counter top is very stained and the wall behind has paint peeling off of it;
-there is a hole in the wall and the baseboard is coming off the wall beside the refrigerator/counter.
The Administrator shared that the expectation is that the home, furnishings and equipment are kept clean, sanitary and maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 002 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 that there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. The home has developed a quality improvement and utilization review system but not all components have been implemented as evidenced by the following:
The major issues identified in the Residents' Satisfaction Survey of October 2011 remain outstanding, such as:
* Laundry, missing clothing, not processed promptly – A new labeling form and procedure was to be implemented by October 15, 2012, to avoid any mislabeling, missing clothing and labeling on time. There is no documented evidence of a new labeling form and procedure implemented and on November 6, 2012 at 10:45 am, this was confirmed by the Environmental Services Supervisor.
* Food Service, temperatures, look of meals, overall satisfaction – An in-service was to be held to enforce with dietary aides the need to ensure the food is plated in an attractive manner. There is no documented evidence that an in-service was conducted and this was confirmed by the Food Service Supervisor.
* Fire Safety – Signage was to be posted on the back of each bedroom door notifying residents what to do in the event of a fire. Inspector # 137 observed that there was no signage posted on the bedroom doors in Kent, Elgin and Oxford and this was confirmed by the Staff Educator. Also, the Residents' Council and residents were to be informed of Fire Procedures in the home. The Staff Educator confirmed that this had not occurred.
The Environmental Services Supervisor, Food Service Supervisor, Life Enrichment Coordinator and Staff Educator all confirmed that the issues identified in the October 2011 Residents' Satisfaction Survey have not been acted upon, except for the Family Council being informed of the Home's Fire Procedure.

2) A review of 14 maintenance audits, conducted between March 16 - October 15, 2012, revealed that the ballasts require replacing in Elgin and Oxford hallway lighting. A quote was submitted to Corporate Office in March 2012.
A review of housekeeping audits, conducted between March 16 – October 15, 2012, revealed that the finish on floors is not in good condition as schedules were not compliant, due to floor scrubber breakdown and schedules for cleaning rooms, refinishing and buffing floors were postponed, waiting for a floor scrubber.
A quote was submitted to Corporate Office on November 29, 2011.
While these deficiencies have been identified, no action plans have been developed to correct the deficiencies.
A review of the Administrator's Walk-through Audit of April 2012 revealed a problem/deficiency with privacy curtains being soiled. The action plan was that a new program and schedule will be in effect to wash privacy curtains. There is no

documented evidence that a new program and schedule is in place and this was confirmed by the Environmental Services Supervisor. [s. 84.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. A written notification of non-compliance and a voluntary plan of correction were previously issued on October 5, 2011, related to the Head to Toe Skin Assessment Policy, not being complied with.

Classic Care Pharmacy
Subject: Safe Storage of Medication
Policy Number 4.8
Revision Date: October 2010
Medications, which require refrigeration, are stored in a refrigerator in the medication room or in a locked box in a refrigerator. The medication refrigerator should: Have a thermometer to monitor temperature; be maintained between 2 and 8 degrees Celsius.
Narcotic and controlled substances are stored separately, with no other articles, and always maintained under double-lock. They must be: Stored in a stationary narcotic box in the medication cart or in a stationary narcotic cupboard or box in the medication room.
Clonazepam was observed to be stored in the regular strip packaging. Lorazepam ordered PRN was observed stored in a card in the bottom drawer of the medication cart. Injectable lorazepam 4mg/ml was noted to be stored in the medication fridge in the medication room and the medication fridge temperatures are not monitored. [s. 8. (1)]

2. Evidence of non-compliance captured in #'s 1, 3, 4, 5, 6, 7, 8, 9 and 10. [s. 8. (1)]

3. The home has not implemented a policy related to immunizations against tetanus and diphtheria, as required, in the regulations.
The Co-DOC/designated Infection Control Practitioner confirmed that the policy entitled, Tetanus and Diptheria Immunization, dated September 2012, has not been implemented in the home and it was just received from corporate when MOHLTC inspectors requested the policy. [s. 8. (1)]

4. The Tray Service for Residents policy, dated May 2007, was not followed when an identified resident was provided tray service and was observed eating in the resident's room with no staff in the vicinity, on October 17, 2012, at the lunch meal. The policy states "the resident will be brought their meal by the nursing care staff and the staff member will stay with the resident throughout the meal. A resident eating alone in their room is at risk for choking".

The registered dietitian confirmed that the expectation is that the policy be followed for all residents who eat in their rooms. [s. 8. (1)]

5. The home's policies regarding height monitoring being done annually are inconsistent. One policy was not followed and the other policy does not meet the expectations in the regulations.
The policy entitled Measuring Height, dated October 2010, in the Nutrition manual states that heights are to be taken annually but 10 of 10 record reviews confirmed that they have not been taken annually.
The DOC confirmed that the nursing policy entitled Height Measurement, dated May 2007, from the Resident Care manual does not meet current regulation as it does not indicate that the heights are to be taken annually. [s. 8. (1)]

6. Jarlette Health Services-Policy subject: Medication Management System - Drug Storage; Manual: Resident Care
Revised Date: Feb 2010 states:
Ensure that all narcotics and controlled drugs are stored in a double locked, permanently affixed compartment within the general medication cart and or medication room.
Ensure that during the distribution of medications, that the medication cart and medication room is kept locked when not attended.
Ensure that no medication is left on top of the medication cart when the Registered Staff is not in attendance.
During this inspection it was noted that controlled drugs are not stored in a double locked, permanently affixed compartment within the general medication cart and medication room.
The policy was not followed as evidenced by controlled substances were observed in the medication cart and the medication fridge and were not double locked; and medication/treatment carts were unlocked and unattended and/or medication left on top of the cart and cart unattended on 8 occasions during this inspection. [s. 8. (1)]

7. The home is not complying with their policy entitled Documenting Resident Attendance, dated June 2008, from the Life Enrichment manual. The policy contains 14 participation codes that are to be used to document resident participation in all life enrichment activities.
However, the legend currently used to document participation only has 10 codes and many of them do not match the codes in the policy. As an example, N in the policy

indicates inactive while N in the current legend indicates not available. Likewise, L in the policy indicates Leave of Absence/ Out of the building while L is currently being coded for Own Leisure.
The Life Enrichment Coordinator acknowledged that the home is not following their documentation policy.
It was also noted that the documentation for the month of October was not always accurate. The following errors were noted:
One identified resident was coded with an A for Active participation at Fitness on October 18, 2012. However, it was observed that the resident slept through this activity.
Another identified resident is not coded as being at Fitness on October 18, 2012. The resident did attend although slept throughout it.
A deceased resident was coded as actively participating in shuffleboard, on October 27, 2012.
Another identified resident was coded with an A for Active participation in craft workshop on October 3, 2012. However, the resident is unable to participate actively in many recreational activities related to cognitive impairment and physical disabilities.
The Life Enrichment Coordinator acknowledged that the coding for these residents was not done correctly. [s. 8. (1)]

8. A review of the Quality Council Overview Policy, dated January 2009, revealed that the meeting minutes were to be posted in the home and that membership includes front line staff, volunteers and representation from Residents' and Family Councils. The Administrator confirmed that the minutes are not posted and membership consists of the management team only.

A review of the Call Bell System Policy, dated May 2007, revealed all call bells are to be checked yearly for proper functioning. There is no documented evidence that the nurse call system has been tested and, on November 6, 2012 at 3:00 pm, this was confirmed by the Environmental Services Supervisor (ESS). [s. 8. (1)]

9. A review of the Maintenance Manual Policy "Electrical Fixtures", dated January 2007, revealed the nursing home is to be checked daily for any faulty or burnt out lights and replace immediately.
This policy has not been complied with as evidenced by Inspector # 137 observed light bulbs to be not working in the following areas:
Elgin Lounge - 1 of 4 ceiling lights was not working.

Alcove across from DOC office - 3 of 5 lights in the ceiling fixture were not working.
Kent Lounge - 2 of 4 ceiling lights were not working.
Sconce light on wall near E5 was not working.
Oxford Lounge 1 of 4 ceiling lights was not working.
Several fluorescent light tubes in Elgin and Oxford hallways were not working. ESS confirmed that the ballasts need to be replaced.
In one bedroom on Elgin and three bedrooms on Oxford, the bedroom ceiling light fixtures contained only one light bulb, rather than two, or two bulbs with only one working. The ESS confirmed this. [s. 8. (1) (b)]

10. Review of Jarlette Health Services Policy
Subject: Head to Toe Assessment
Manual: Resident Care Manual
Section: PCC Documentation
Revised Date: June 2011
Policy states that the Head to Toe Skin Assessment will be completed on every resident at risk of altered skin integrity within 24hrs of admission, upon return from hospital and following leaves of absence greater than 24 hours. An identified resident returned from hospital but the resident's Head to Toe Skin Assessment was not initiated until approximately 38 hours after returning from hospital. The assessment is still not signed as completed 15 days after returning from hospital. This was confirmed by The Director of Care. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

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

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

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. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
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. 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. There is no evidence to support that the Infection Prevention and Control (IPC) program has been updated and evaluated at least annually. The IPC manual contains policies primarily from 2006.
The DOC confirmed that some of the policies are very outdated and they would not actually refer to them because they would not meet evidenced based practices. She also confirmed that the program has not been evaluated nor updated at least annually. [s. 229. (2) (d)]

2. Infection control risks were observed in six shared resident rooms/washrooms including:
-unlabeled personal care items including hair and tooth brushes, denture cups, deodorant, and toothpaste; and
-improperly stored items sitting on bathroom floors or night stands including dirty wash basin, urinal containing urine and raised toilet seats on the floor.
During an interview with the DOC the following expectations were confirmed:
a) Personal care equipment, including urinals, raised toilet seats and wash basins are to be cleaned, disinfected and stored properly after each use;
b) Nursing supplies are expected to be stored in a clean utility room; and
c) Hair and tooth brushes, denture cups, toothpaste deodorant and personal skin care products are to be labeled for resident's individual use and not to be used communally. [s. 229. (4)]

3. Inspector # 137 observed bottles of mouthwash, denture tablets and shaving cream stored on a shelf in Soiled Utility Room on Oxford.
Two used, unlabeled deoderant sticks were observed in the Oxford Tub Room.
An unlabeled urinal, containing urine, was observed on a bedside table on Kent.
It was observed that one wall mounted hand sanitizer was broken and another one was empty on Lambton. It was also observed that two wall mounted hand sanitizers were empty on Kent. [s. 229. (4)]

4. Evidence of non-compliance captured in #'s 2 and 3. [s. 229. (4)]

5. There is no documented evidence to support that information that was gathered daily related to infections in residents is reviewed monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks.
The Co-DOC/designated Infection Control Practitioner stated that she realized that they really weren't doing a very good job of completing the monthly reviews and

acknowledged that the home was not meeting expectations. [s. 229. (6)]

6. A review of immunization records revealed that six identified residents have not been adequately screened for tuberculosis because the second step of the 2 Step screening was not administered, despite receiving Step 1 of the TB test being done within 14 days of admission:
Resident # 1 - 167 days post admission;
Resident # 2 - 169 days post admission;
Resident # 3 - 715 days post admission;
Resident # 4 - 205 days post admission;
Resident # 5 - 713 days post admission;
Resident # 6 - 697 days post admission.
Another identified resident has not been screened for tuberculosis within 14 days of admission, and is now 340 days post admission. [s. 229. (10) 1.]

7. Evidence of non-compliance captured in # 6. [s. 229. (10) 1.]

8. Inspector # 137 observed that there is no vaccine for tetanus and diphtheria in the vaccine refrigerator.
A review of immunization records for 10 residents revealed that none of the residents (100%) have been offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
The DOC confirmed that none of the residents in the building have received the immunizations. [s. 229. (10) 3.]

9. Evidence of non-compliance captured in # 11. [s. 229. (10) 4.]

10. Evidence of non-compliance captured in # 11. [s. 229. (10) 4.]

11. Medical records were reviewed, with the Office Manager, for staff hired since May 22, 2012 and 8 of 10 staff files did not have evidence of screening for tuberculosis. One of the 10 staff had step one of the 2 step TB test completed but step 2 was never administered. One of the 10 employees had step one administered within 14 days of hire but the home was reported to not have any serum so step one was repeated 69 days post hire.
The DOC confirmed that the expectation is that all staff have their TB tests done upon

hire before they commence working in the home. [s. 229. (10) 4.]

12. Immunization records were not available for all pets visiting the home as part of the pet visitation program. The home only had records for one of three dogs visiting as part of the St. John's Ambulance pet therapy program.
Three other dogs were observed during the inspection and it was reported that two of them visit residents on a regular basis.
The Volunteer Coordinator acknowledged the need for the records and was able to obtain the records for the other two dogs, from the St. John's Ambulance program, after they were requested by inspectors. [s. 229. (12)]

Additional Required Actions:

CO # - 005 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 that all staff participate in the implementation of the infection prevention and control program and that the information gathered, related to infections, is reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Call bells were observed not to be functioning, on October 19, 2012, in the washrooms of two identified rooms on Lambton.
A personal support worker confirmed that the call bells were not working.
MOHLTC Inspector informed the home of this safety risk and the call bells were noted to be working on October 22, 2012.
A staff interview with DOC confirmed that the expectation is that residents' call bells are working and can be used by residents at all times.
On October 19, 2012 at 3:30 pm, the call bells in Oxford and Elgin tub rooms were observed, by Inspector # 137, as not being visible and accessible, as well as were obstructed by care supply carts. The pull cords were not attached at the activation point. The Director of Care was informed and was also unable to locate the call bell until shown the location by the Inspector. The Administrator was made aware and confirmed that the call bells were not visible and access was obstructed.
On October 22, 2012 at 9:32 am, the call bell in Oxford tub room was again observed not visible and access was obstructed by the care supply cart. [s. 17. (1) (a)]

2. Observation of the Kent, Oxford, main lobby area and two Lambton lounges, as well as the Oxford, Elgin and Lambton dining rooms and the Chapel, revealed that there is no resident-staff communication and response system available.
Personal support workers, housekeeping aides and the Life Enrichment Coordinator confirmed that there were no call bells accessible to residents, staff and visitors, in all of these areas. [s. 17. (1) (e)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. Temperatures were taken in all areas of the home, October 29, 2012, between 10:54 and 11:26 am. The identified rooms were not at the required minimum temperature of 22 degrees. The temperatures ranged from 18 - 21.3 degrees Celsius.
Three residents expressed concerns about the temperature of the building being too cold.
Two personal support workers stated that they were cold and that residents were complaining of being cold.
Two residents in bed were observed with the blankets over their heads.
Lambton dining room - temperature was 21.3 degrees Celsius;
Lambton hallway - temperature was 21.5 degrees;
A resident near Lambton lounge complained that it was cold in here but stated he/she was okay right now;
The environmental services supervisor acknowledged, in an interview, of being aware that the home needed to be at a temperature of at least 22 degrees Celsius and that the thermostat had been adjusted. The ESS was not sure if it would increase the temperature immediately.
Later that day, the administrator acknowledged that there had been previous concerns identified related to the heating system and arrangements were made a month ago with a heating company to address the concerns. The company was noted to be on-site after the MOHLTC Inspector had identified concerns regarding the heating. [s. 21.]

2. Evidence of non-compliance captured in # 1. [s. 21.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

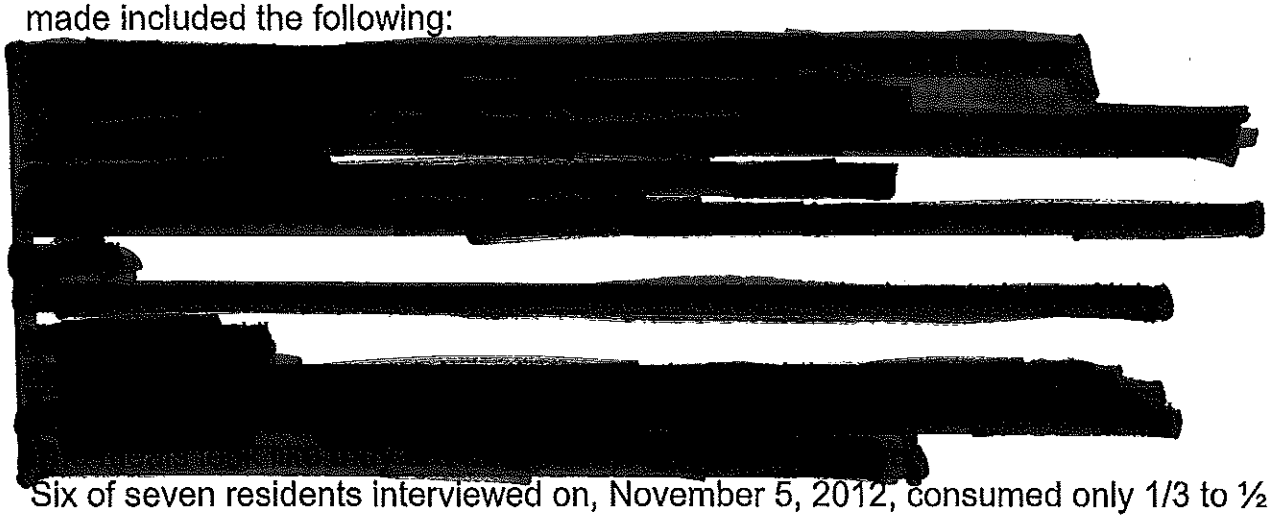
s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(b) a cleaning schedule for all the equipment; and O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. A previous written notification of non-compliance and a voluntary plan of correction were issued on May 2, 2012, related to residents' dissatisfaction with meals

Nine residents expressed concerns about the quality/taste of the food. The comments made included the following:



Six of seven residents interviewed on, November 5, 2012, consumed only 1/3 to ½ their lunch meal entrees.
Plate waste was noted at lunch, November 5, 2012, with at least 1/2 the entrée from 12 of 12 plates observed being scraped into the garbage. Additionally, 8 of 8 residents observed did not consume the corn/black bean salad on October 17, 2012 and it was all scraped into the garbage.
The food service supervisor acknowledged that plate waste is not monitored in the dining rooms in terms of assessing the quality of the food and residents' satisfaction with the taste of the food. [s. 72. (3) (a)]

2. Evidence of non-compliance captured in # 1. [s. 72. (3) (a)]

3. Although there are cleaning schedules for the dining and snack areas, they are not complied with as evidenced by the following observations in the main dining room:
-there is a build up of dirt around the baseboard on the floor;
-the garbage can is covered with stains and beverage spills and debris;
-there is a build up of dirt and food debris on the counter top and the wall behind;
-the household toaster is stained and dusty;
-the cupboards have a build up of spilled food and beverages on them;
-the floor space between the cupboards and the refrigerator has a build up of debris;
-the refrigerator has spills in it and the handles are stained &/or have a build up of

debris.
The food service supervisor acknowledged that housekeeping is an issue in the home and that the cleaning schedules for equipment and dining/servery areas have not been complied with. [s. 72. (7) (b)]

Additional Required Actions:

CO # - 008 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 that the home has cleaning schedules for all the equipment and that they are complied with, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

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:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

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:
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. O. Reg. 79/10, s. 73 (1).

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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. A previous written notification of non-compliance and a voluntary plan of correction were issued on May 2, 2012, related to not using proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

Review of Resident Council Minutes revealed that the dining and snack times were not reviewed by Residents' Council. A Resident Council representative and Life Enrichment Coordinator confirmed that the dining and snack times were not reviewed by the Residents' Council. [s. 73. (1) 2.]

2. Evidence of non-compliance captured in # 1. [s. 73. (1) 2.]

3. An identified resident was provided tray service in the resident's bedroom at the lunch meal on October 17, 2012, with no staff in the vicinity for supervision.
A registered nurse, who was with inspector #128, observed the resident and confirmed that the home's expectation is that whoever took the tray to the resident was expected to stay with the resident to monitor while the resident was eating. [s. 73. (1) 4.]

4. Observations of the afternoon snack cart, on October 31, 2012, revealed that two identified residents were not provided with assistive devices required to safely eat and drink.
The food service supervisor confirmed that the expectation was that assistive devices were to be available on the snack cart and used by staff. [s. 73. (1) 9.]

5. On October 24, 2012, a PSW was giving an identified resident thickened fluids while the resident was seated in a reclined position. The current care plan indicates that the resident is to be in tilt position at all times, other than just prior to consuming meals. A registered practical nurse confirmed that the resident is a choking risk. [s. 73. (1) 10.]

6. Evidence of non-compliance captured in #'s 5, 7, 8 and 9. [s. 73. (1) 10.]

7. An identified resident's current kardex indicates that the resident is to be properly positioned for all oral intake and 30 minutes afterward.
During lunch meal on October 17, 2012, the resident was in a reclined position while a PSW was feeding the resident thickened fluids and the fluids were running out of the

resident's mouth. Inspector asked that the resident be repositioned due to not being in a safe position and the request was complied with. [s. 73. (1) 10.]

8. A personal support worker was observed standing to feed an identified resident thickened fluids, on October 18, 2012, at afternoon snack. The resident was not in a safe feeding position and was sitting reclined at approximately a 110 degree angle. The PSW acknowledged that resident was at choking risk and put the resident in an upright position, after MOHLTC Inspector's intervention.
The DOC confirmed that the expectation is that all residents are positioned safely while being assisted with eating and that residents should be placed at a 90 degree angle to ensure safety. [s. 73. (1) 10.]

9. Observations of the afternoon snack cart, on October 31, 2012, revealed that proper techniques, including safe positioning of residents were not used to assist six identified residents who required assistance with eating.
*Resident # 1 started to cough while being provided a drink. The PSW sat down and when the resident stopped coughing, the PSW stood up again. The resident started to cough again.
The plan of care for this resident revealed that risk of choking/aspiration and ensuring appropriate positioning were identified.
*Resident # 2 was not at a safe feeding position while a personal support worker stood to provide the resident a snack, placing the resident at risk of choking. The PSW sat down part way through the snack but then stood to provide the resident with the beverage.
The plan of care for this resident revealed that risk of choking/aspiration was identified.
*Resident # 3 was not at a safe feeding position while a personal support worker stood to provide the resident with a drink, placing the resident at risk of choking.
*Resident # 4 was not at a safe feeding position while a personal support worker stood to provide the resident with some pudding, placing the resident at risk of choking.
*Resident # 5 was not at a safe feeding position while a personal support worker stood to provide the resident with a pureed snack and juice, placing the resident at risk of choking.
*Resident # 6 was not at a safe feeding position while a personal support worker stood to provide the resident with juice. The resident's chair was also not in an upright position, placing the resident at risk of choking.

The DOC and registered dietitian both confirmed that the expectation was that all staff must ensure every resident was at a safe feeding position while being provided with food and fluids. [s. 73. (1) 10.]

Additional Required Actions:

CO # - 009 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 that the home has a dining and snack service that includes, at a minimum, monitoring of all residents during meals and providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. A written notification of non-compliance and a voluntary plan of correction were previously issued on May 2, 2012.

On October 26 and October 29, 2012, interviews were conducted with 8 staff members and all revealed that the home frequently runs out of linens on a daily basis, including top sheets, bottom sheets and bath towels.
A tour of the linen rooms, on October 29, 2012 between 7:58 - 8:15 am, revealed that there was a shortage of bottom sheets on Oxford, top sheets, bed spreads and slings on Kent, top and bottom sheets on Lambton and bath towels on Elgin.
There were no sheets in Oxford, no linens in Kent, 8 pillow cases in Lambton and some aprons and peri-cloths in Elgin.
There was not a sufficient supply of clean linens, face cloths and bath towels always available in the home for use by the residents. [s. 89. (1) (b)]

2. Soiled privacy curtains were observed throughout the RQI in 11 identified rooms. [s. 89. (1) (c)]

3. Observations conducted by two inspectors (# 137 and # 155) throughout the RQI revealed the following:
Lambton – pillow cases and sheets observed to be stained, worn, had holes and were discoloured in 7 identified rooms. A mattress cover was observed to be worn.
A therapeutic surface cover was observed to be soiled and had a strong urine odour detected from it.
Kent – observed stained sheets in two identified rooms. Several sheets and pillow cases on beds and care cart were observed to be discoloured.
Elgin – pillow cases and sheets observed to be worn and had holes in two identified rooms.
Oxford – observed worn and stained pillow cases in two identified rooms. [s. 89. (1) (c)]

4. Evidence of non-compliance captured in #'s 2 and 3. [s. 89. (1) (c)]

5. Evidence of non-compliance captured in #'s 2 and 3. [s. 89. (1) (c)]

Additional Required Actions:

CO # - 010 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. A medication cart was observed unlocked and unattended sitting near the window by the administration area on October 31, 2012. A registered staff walked from the Oxford hallway past the cart to the lounge area near the front entrance. The cart was removed from the area and taken to the administrator's office. Registered staff were not in view of the cart. [s. 129. (1)]

2. Inspector # 128 observed a treatment cart unlocked and unattended with two prescription creams sitting on the top of it, as well as inside the cart, on October 31, 2012, in the Lambton secure wing.
The RPN was in the tub room for four minutes while the cart was unattended.
The RPN acknowledged that it "probably should have been locked", but indicated the expectation is more so with medication carts. [s. 129. (1)]

3. Inspector # 128 observed a treatment cart unlocked and unattended with prescription creams inside the cart, on October 31, 2012, in the Oxford wing.
The DOC confirmed the expectation is that treatment carts are to be locked at all times and in the medication room when unattended.
The DOC took the treatment cart and put it in the medication room. [s. 129. (1)]

4. On October 31, 2012, Inspector # 128 observed an unattended medication cart with crushed medication in applesauce and prescription eye drops sitting on the top of the cart.
The Care Services Coordinator was made aware, confirmed observation, expressed concern and removed the cart to the administration office. [s. 129. (1)]

5. On October 26, 2012 at 8:30 am, Inspector # 137 observed the medication cart, in Kent, to be unlocked, unattended and there were 7 medications in a medication cup, situated on top of the MAR, as well as a bottle of Diclofenic topical solution on top of the medication cart.
A registered practical nurse was observed to be in the dining room and returned to the medication cart at 8:35 am. [s. 129. (1) (a)]

6. On October 25, 2012 at 9:25 am, Inspector # 155 entered the Lambton secure unit and observed the medication cart unattended, outside of the activity room. There was a bottle of Pediatrix Drops 80mg/ml 500 ml bottle that was 3/4 full. Residents were coming out of the doorway where the medication cart was located. A registered practical nurse came out of the dining room at 0930 hours. The inspector introduced

self to the RPN, who then opened the medication cart and put the bottle of Pediatrix drops 80mg/ml away in the cart. [s. 129. (1) (a)]

7. On October 25, 2012, a registered practical nurse had the Oxford medication cart parked by the administration office doorway. At 11:28 hours, the RPN left the medication cart unattended and unlocked and entered the dining room to administer medications to a resident. At 1205, the RPN again left the medication cart unlocked and unattended and entered the dining room to administer medications to a resident. [s. 129. (1) (a)]

8. During observation of a medication pass, it was revealed that controlled substances, such as Benzodiazepines, are not stored in a separate locked area within the locked medication cart.
This was confirmed by a Registered Practical Nurse. [s. 129. (1) (b)]

9. An identified resident is on Clonazepam which was in the regular strip packages and is not stored in a separate locked area within the locked medication cart.
Another identified resident is prescribed Lorazepam and the tablets were in a card in the bottom drawer of the medication cart.
The Emergency drug box that is kept in the Oxford/Elgin medication room contained Lorazepam with 7 tablets in a card and this emergency drug box is not stationary or locked. The emergency box also contains 10 vials of Lorazepam 4mg/ml which was in the refrigerator in the medication room.
Registered staff confirmed that these controlled substances are not stored in a separate locked area within the locked medication cart. [s. 129. (1) (b)]

Additional Required Actions:

CO # - 011 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 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, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
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. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
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. 2007, c. 8, s. 3 (1).
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in

accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

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. 2007, c. 8, s. 3 (1).

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. 2007, c. 8, s. 3 (1).

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).

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. 2007, c. 8, s. 3 (1).

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. 2007, c. 8, s. 3 (1).

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).

19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
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. 2007, c. 8, s. 3 (1).
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. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
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. 2007, c. 8, s. 3 (1).
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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. A written notification of non-compliance was previously issued on May 2, 2012, related to not affording privacy during treatment and care needs.

An identified resident was not afforded any acoustic privacy while being provided a bath in the Lambton tub room, at [redacted]. Although the privacy curtain was pulled around the tub, staff were bathing the resident with the tub room door open and the conversations could be overheard.
The Lambton tub room door was observed to be open while providing baths to residents every day of the inspection.
A staff interview with the Director of Care confirmed that her expectation is that residents are afforded privacy and treated with dignity at all times. [s. 3. (1)]

2. Evidence of non-compliance captured in #'s 1, 3, 4, 5, 6, 7 and 8. [s. 3. (1)]

3. Three identified residents were observed not to be provided privacy while receiving treatments, administered by a registered nurse, in the Lambton wing, on October 26, 2012:
*Resident # 1 was observed having glucose monitoring done in the dining room;
*Resident # 2 was observed having glucose monitoring done at the nursing station; and
*Resident # 3 was observed receiving ventolin puffer via a chamber at the nursing station. [s. 3. (1)]

4. A registered staff member was observed checking the blood glucose level of an identified resident and administering insulin to the same resident at the main nurses' desk and dining room entrance. There were several other residents present in the front lounge and dining room areas.
A registered staff member was observed administering eye drops to an identified resident at the main nurses' desk and dining room entrance. There were several other residents present in the front lounge and dining room areas. [s. 3. (1) 8.]

5. The following were observed on [redacted]:
[redacted] resident in Oxford tub room having a bath. Door observed open with privacy curtain drawn but not fully closed.
[redacted] Resident in Elgin tub room having a bath. Door was observed open, with privacy curtain drawn.

[redacted] Observed tub room door open with privacy curtain drawn in Lambton Tub Room, while resident was having a bath.
[redacted] Two caregivers shared that baths are done with the tub room door open so that they can hear what is going on, on the unit. There are only two PSW's on the unit for 15 minutes of the RPN's break and both are in the tub room. The other two PSW's are also on break.
[redacted] - Observed 2 PSW's taking female resident into Oxford tub room. Door remained open and privacy curtain was drawn. Able to hear all verbal interactions.
[redacted] - Observed Elgin Tub Room door open with privacy curtain drawn. [redacted] resident was being bathed.
[redacted] - Inspector observed Oxford Tub Room door open, with privacy curtain drawn. A male caregiver was overheard giving a resident a bath and giving resident direction. [s. 3. (1) 8.]

6. A registered staff member was observed administering eye drops to an identified resident as the resident was seated at a dining room table. There were other residents present in the dining room and front lobby area. [s. 3. (1) 8.]

7. Privacy screens in 3 identified Lambton rooms were observed not to provide full privacy as they were not large enough to surround the beds. In an identified shared room, the bed that had the privacy screen that was too small was next to the window and there were no curtains on the exterior window, either.
Staff interviews with personal support workers revealed that they try to change residents' in their washrooms if the privacy screens are not large enough.
A staff interview with the DOC revealed that the home's expectation is that all residents are provided privacy at all times and that privacy screens must surround beds and all exterior windows must have curtains. [s. 3. (1) 8.]

8. On [redacted] Inspector # 137 observed a resident being bathed in Oxford Tub Room, with the tub room door open and privacy curtain drawn. The DOC was informed, observed and confirmed. [s. 3. (1) 8.]

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 every resident has the right to be afforded privacy in treatment and caring for his or her personal needs, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. On October 30, 2012 @ 3:17 pm, Inspector # 137 observed an unlocked and unattended maintenance cart in an identified room on Lambton. The bedroom door was open with direct resident access to the cart, which contained nails, plyers, screw drivers, drill, fluorescent light tubes and a ladder.
At 3:22 pm, the Administrator and Director of Care observed the cart and confirmed that it was unlocked and unattended.
The Administrator shared that ensuring resident safety had been discussed earlier in the day with the person providing maintenance services in Lambton. [s. 5.]

2. On November 6, 2012 at 13:05, inspector # 128 observed a hot water urn attached to the coffee maker in the main dining room which was accessible to residents. The water was probed at 86.1 degrees Celsius.
The administrator acknowledged that this was a safety risk as water that hot would burn fragile skin. [s. 5.]

3. Evidence of non-compliance captured in # 1 and 2. [s. 5.]

Additional Required Actions:

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

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 10. Recreational and social activities

Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that there is an organized program of recreational and social activities for the home to meet the interests of the residents. 2007, c. 8, s. 10 (1).

Findings/Faits saillants :

1. There is no documented evidence to support that there is an organized program of recreational and social activities for the home to meet the interests and include services for residents with cognitive impairments.
Observations over 2 days of the inspection revealed that there was only one activity in the secure Lambton unit.
A review of the attendance records revealed at least 25 of 31 (80%) of the residents living in the Lambton wing (secure unit) did not attend an activity nor have a 1:1 visit for 11 of the 31 days (35%) in the month of October. There were 3 days in the month where 93.5% of the residents did not attend an activity nor have a 1:1 visit and one day of the month when 96.7% of the residents in Lambton did not attend an activity. The one resident who did attend an activity on that day participated in "mail delivery".
The Life Enrichment Coordinator acknowledged that it is a challenge to try to offer enough activities in the secure Lambton wing with the limited staffing available. The Life Enrichment Coordinator also acknowledged that it is difficult to have enough staff to supervise residents from Lambton while they are at activities off the secure unit.
Additionally, it was noted that although the Lambton unit has a separate activity calendar, all of the activities on the calendar are not provided to residents. The first week of October was reviewed for discrepancies and that week alone, there were four activities on the Lambton calendar that were not documented as being held. These activities were not scheduled to be held in other areas of the home. Additionally, there were 11 other activities scheduled that week on the Lambton calendar, to be held in other areas of the home that no residents from Lambton attended.
The Life Enrichment Coordinator acknowledged that all activities scheduled should be held. [s. 10. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is an organized program of recreational and social activities for the home to meet the interests of the residents and that the program shall include services for residents with cognitive impairments, and residents who are unable to leave their rooms, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. On October 18, 19 and 22, 2012, privacy curtains in 4 identified rooms were observed not to provide full privacy to residents, when curtains were drawn around the beds. [s. 13.]

2. Privacy screens in 3 identified shared rooms on Lambton did not fully surround the beds.
Personal support workers confirmed that the screens were not large enough to provide full privacy.
Staff interviews with personal support workers revealed that they inform maintenance when privacy curtains need to be adjusted or are not big enough to surround the bed.
The ESS stated that quarterly reviews are done of each room. However, documentation reviewed from the audits, conducted in July 2012, for the Lambton rooms revealed that the privacy screens were not checked. [s. 13.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must 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. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).

Findings/Faits saillants :

1. There is no documented evidence that any of the required programs have been evaluated and updated at least annually in accordance with evidence-based practices. This was confirmed on November 5, 2012 at noon by the The Director of Care and on November 6, 2012 at 10:55 am by the Co-Director of Care. [s. 30. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each of the required programs must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1.An identified resident indicated during two different interviews of wishing to stay up until after 7 pm but the staff are putting the resident to bed shortly after 6 pm. If the resident asks to stay up staff will put the resident to bed anyway. It was confirmed by a registered staff that the resident is being put to bed before the resident wishes to go to bed. [s. 41.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and O. Reg. 79/10, s. 48 (2).
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Findings/Faits saillants :

1. The falls prevention program does not provide for any assessment instrument to determine resident's risk for falls on admission. This was confirmed by the Director of Resident Care. [s. 48. (2) (b)]

Additional Required Actions:

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

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(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;
O. Reg. 79/10, s. 50 (2).

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

Findings/Faits saillants :

1. An identified resident, with injury sustained during a fall, was admitted to hospital and returned to the home six days later. The Head to Toe Skin Assessment was not initiated until approximately 38 hours after returning from hospital and was still incomplete 15 days later. [s. 50. (2) (a) (ii)]

2. Evidence of non-compliance captured in # 1. [s. 50. (2) (a) (ii)]

3. Evidence of non-compliance captured in # 6. [s. 50. (2) (b) (i)]

4. Evidence of non-compliance captured in # 6. [s. 50. (2) (b) (i)]

5. An identified resident has various stages ulcers. Two of the wounds have not had a wound care reassessment for at least 18 days and another wound has not been reassessed for 12 days. The last assessment indicates that these wounds were increasing in severity.
[s. 50. (2) (b) (iv)]

6. An identified resident returned from hospital and 10 days later the resident's progress notes indicates that the resident exhibited altered skin integrity. A restorative care referral states skin breakdown. There is no documented evidence that a skin assessment was completed, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and the skin breakdown has not been reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

7. Evidence of non-compliance captured in #'s 5 and 6. [s. 50. (2) (b) (iv)]

8. Evidence of non-compliance captured in #'s 5 and 6. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, upon any return of the resident from hospital,using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. Evidence of non-compliance captured in #'s 3 and 6. [s. 68. (2)]

2. Evidence of non-compliance captured in #'s 3 and 6. [s. 68. (2)]

3. A system is in place to monitor food and fluid intake of residents. However, the evaluation component of the system, to ensure risks related to nutrition and hydration are mitigated, has not been demonstrated, as evidenced by the following:
*A review of the documentation for an identified resident's food intake revealed that the resident missed 22 meals and consumed less than 50% at another 5 meals, in the month of October 2012.
The DOC confirmed that this is a problem and that it should have been identified by nursing staff so that a referral could be sent to the registered dietitian.
The dietitian expressed concern that she had not been notified because she was not aware of the identified risk.
*Two identified residents receive snacks in the morning. However, personal support workers identified that there isn't anywhere in Point of Care for them to document that the snacks are being provided.
The RAI coordinator confirmed that the system has not been set up so that staff can document the additional snacks in the morning for these residents.
*Orders are written by the registered dietitian for all residents who receive high energy, high protein milk supplements (HEHP). However, there is no documentation to support that the intake of the supplements is being monitored and evaluated.
Personal support workers do not document the HEHP separately from other fluids so there is no way to track if the supplements are consumed. Forty-four residents in the home receive HEHP supplements.
The food service supervisor and the registered dietitian acknowledged that this was a risk and the HEHP supplements should be documented to assist in evaluation of residents' nutrition and hydration status. [s. 68. (2) (d)]

4. Evidence of non-compliance captured in # 3. [s. 68. (2) (d)]

5. Evidence of non-compliance captured in # 3. [s. 68. (2) (d)]

6. Ten of ten resident charts reviewed revealed that the weight monitoring system does not include measurement of heights annually for each resident.
An interview with the registered dietitian confirmed that the expectation is that residents' heights are measured annually. [s. 68. (2) (e) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration and that heights be recorded upon admission and annually thereafter, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

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

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. An identified resident was not in the dining room at the lunch meal on October 17, 2012. The resident was observed sitting in the resident's room without a tray.
A registered nurse stated that the resident is able to decide if about wanting to come to the dining room for meals so the resident was not offered a tray.
A review of the resident's care plan revealed that the resident requires increased supervision and cueing related to progressive cognitive diagnosis and lack of memory.
An interview with the registered dietitian revealed that the resident is cognitively impaired and definitely should have been provided with a tray to ensure that lunch was offered. [s. 71. (3) (a)]

2. At afternoon snack, on October 31, 2012, three identified residents were not offered both a between meal beverage and a snack.
All residents were not offered a choice of beverage and/or snack, either.
The food service supervisor acknowledged that the home's expectation is that all residents are offered a snack and beverage and that residents are to be offered choice, as well. [s. 71. (3) (b)]

3. The planned menu was not provided, in the Oxford wing, on October 31, 2012.
The menu on the snack cart was for Wednesday, Week #2, Fall and Winter. However, the food and beverages outlined on the menu were not the same as what was on the snack cart. The menu stated:
Orange drink, diet orange drink, water, skim milk and 2%milk, tea, coffee, Fresh fruit/diced fruit cup/pureed fruit cup and sugar cookies/pureed sugar cookies.
However, what was actually served was:
Apple drink, diet apple drink, water, whole bananas, unlabelled yellow pudding, chocolate wafer cookies and cream filled cookies, pureed cookies and labelled beverages. No tea/coffee or milk were on the snack cart nor was any pureed fruit available.
When the DOC queried the PSW serving the snack cart as to what would be served as the pureed fruit, the response was that the pudding would be served as the fruit.
The planned menu also stated that all residents were to be offered 125ml water with each snack but only two residents were offered water.
The Administrator and DOC confirmed observations of the food on the snack cart was not the same as the planned menu.
The food service supervisor stated that the menu had changed from the Spring and Summer cycle to the Fall and Winter cycle, on Monday of that week and the staff had used the Spring and Summer menu instead of the Fall and Winter to prepare the

snack cart. He stated that the expectation is that the menu is to be provided to residents as per the diet lists and that dietary staff provide all required items on the cart [s. 71. (4)]

4. Evidence of non-compliance captured in # 3. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident is offered a minimum of three meals daily, a between-meal beverage in the morning, and afternoon and a beverage in the evening after supper and a snack in the afternoon and evening, as well as to ensure that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

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:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(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; 2007, c. 8, s. 78 (2)
(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; 2007, c. 8, s. 78 (2)
(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; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(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; 2007, c. 8, s. 78 (2)
(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; 2007, c. 8, s. 78 (2)

(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(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; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. A review of the admission package revealed that there is no documented evidence that the package includes the home's mission statement. The Administrator and Resident & Family Services Coordinator confirmed this. [s. 78. (2) (b)]

2. A review of the Admission Package and the brochure "A Guide for Residents and Families in Long Term Care" revealed that there is no documented evidence that the package includes the name and telephone number of the licensee.
This was confirmed by the Resident and Family Services Coordinator. [s. 78. (2) (h)]

3. A review of the admission package revealed that there was no documented evidence that the package included a statement of the maximum amount that a resident can be charged for each type of accommodation offered in the home. The Resident and Family Services Coordinator confirmed this. [s. 78. (2) (i)]

4. A review of the admission package revealed that there was no documented evidence that the package included information about what is paid for by Ministry funding, and accommodation payment by the resident. The package did include information regarding "uninsured services". The Resident and Family Services Coordinator confirmed this. [s. 78. (2) (k)]

5. A review of the admission package revealed that the package did not include a disclosure of any non-arm's length relationships that exist between the licensee and other providers who offer care, services, programs or goods to residents.
The Resident and Family Services Coordinator confirmed this. [s. 78. (2) (n)]

6. A review of the admission package revealed that there is no documented evidence that the package includes information about the Residents' Council. The Resident and Family Services Coordinator confirmed this. [s. 78. (2) (o)]

Additional Required Actions:

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

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. There is no documented evidence that the licensee ensures procedures are developed and implemented for the cleaning of privacy curtains. An interview, conducted with the Environmental Services Supervisor, confirmed that there is no policy and procedure for cleaning privacy curtains and that the task was not included in the housekeeping job routine. [s. 87. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure, as part of the housekeeping program, that procedures are developed and implemented for cleaning of the home, including privacy curtains, to be implemented voluntarily.

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).
(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service; O. Reg. 79/10, s. 90 (2).
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and O. Reg. 79/10, s. 90 (2).
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has not ensured that procedures are developed and implemented to ensure that call bells are working at all times.
Staff interviews with the DOC and Co-DOC revealed that the expectation is that nursing is responsible for ensuring that the call bells are accessible to residents but there isn't a system in place to ensure that call bells are working. They stated that maintenance was responsible to ensure that call bells are working.
However, the ESS indicated in an interview that it is the responsibility of nursing to ensure that the call bells are working on a day to day basis. Maintenance conducts quarterly audits of each resident room. [s. 90. (2)]

2. Evidence of non-compliance captured in # 1. [s. 90. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment, to be implemented voluntarily.

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. A housekeeping room, containing hazardous chemicals was observed open and unattended in the Kent wing, during the initial tour of the home.
A Personal Support Worker in the area, a housekeeping aide and a registered nurse all acknowledged that the expectation is that the housekeeping room is to be locked at all times. [s. 91.]

2. Evidence of non-compliance is captured in #'s 1, 3 and 4. [s. 91.]

3. A staff washroom, in the Elgin wing, was observed to be open and unattended, containing a hazardous chemical.
An activity aide confirmed that the expectation is that the washroom is closed and locked at all times. [s. 91.]

4. On October 26, 2012 @8:50 am, a housekeeping cart was observed to be unlocked and unattended outside an identified room on Lambton. The housekeeper was in another room cleaning the washroom and the cart was not visible to the housekeeper. ACCEL TB disinfectant and toilet bowl cleaner were stored in the unlocked cabinet of the cart and were accessible to residents.
8:55 am – Again, the Housekeeping cart was observed to be unlocked and unattended. The housekeeper left the cart and walked around the area between the Lambton nurses' desk and tub room. The cart was not visible to the housekeeper. [s. 91.]

5. Evidence of non-compliance captured in # 1,3 and 4. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances at the home are labeled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. An identified resident had a physician's order for Tylenol 325 mg. – one tablet QID PRN. A review of the Medication Administration Record revealed that the resident received Tylenol 325 mg. – two tablets (twice the amount ordered by the physician), on 56 occasions, between October 1 - 25, 2012. A registered nurse confirmed that the drug was not administered to the resident in accordance with the directions for use by the physician. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. For an identified resident, a review of the Medication Administration Records revealed that the resident received Regular Tylenol, Ativan and Tylenol # 2 PRN. For another identified resident, a review of the Medication Administration Records revealed that the resident received Dilaudid and Ativan PRN.
A registered nurse confirmed that there was no documented evidence of monitoring and the residents' response and effectiveness of the drugs appropriate to the risk level of the drugs. [s. 134. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure when a resident is taking any drug or a combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Discontinued drugs are placed in the Daniels Sharpsmart pharmaceutical waste container. When full, this container is shut so that it locks. It is a plastic container and both DOC and Co-DOC confirmed that the drug is not altered or denatured in this container. It is stored in the locked container until the truck picks up the bins and takes them away. [s. 136. (6)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure when a drug is destroyed that it is altered or denatured to such an extent that its consumption is rendered impossible or improbable, to be implemented voluntarily.

WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
4. The method to apply to the Director for a reduction in the charge for basic accommodation and the supporting documentation that may be required, including the resident's Notice of Assessment issued under the Income Tax Act (Canada) for the resident's most recent taxation year. O. Reg. 79/10, s. 224 (1).

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
5. A list of the charges that a licensee is prohibited from charging a resident under subsection 91 (1) of the Act. O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. A review of the admission package revealed that the brochure, entitled "A Guide for Residents and Families in Long Term Care", contained a statement that the MOHLTC allows for a rate reduction for residents residing in basic rooms who cannot afford to pay the full amount of their accommodation costs. There is no documented evidence that the admission package includes how to apply for a rate reduction.
The Resident and Family Services Coordinator confirmed this. [s. 224. (1) 4.]

2. A review of the admission package revealed that there was no documented evidence in the package that included what the licensee should not be charging a resident for. The Resident and Family Services Coordinator confirmed this. [s. 224. (1) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the admission package for residents contains all required information as identified in the Act and Regulations, to be implemented voluntarily.

WN #30: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. During an interview, an identified resident indicated that staff have only cleaned the resident's top dentures but not bottom natural teeth in two years. Three PSW's/HCA's were interviewed and all indicated that the resident had dentures and did not have natural teeth. [s. 34. (1) (a)]

2. The same identified resident does not receive any physical assistance or cueing with brushing the resident's bottom natural teeth. Interviews, with three PSW's/HCA's, all indicated that the resident had dentures. During an interview, the resident said that staff have not offered any assistance with brushing the resident's natural teeth. [s. 34. (1) (b)]

WN #31: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (1) A Residents' Council of a long-term care home has the power to do any or all of the following:
1. Advise residents respecting their rights and obligations under this Act. 2007, c. 8, s. 57 (1), 195 (4,5).
3. Attempt to resolve disputes between the licensee and residents. 2007, c. 8, s. 57 (1), 195 (4,5).
4. Sponsor and plan activities for residents. 2007, c. 8, s. 57 (1), 195 (4,5).
5. Collaborate with community groups and volunteers concerning activities for residents. 2007, c. 8, s. 57 (1), 195 (4,5).
6. Advise the licensee of any concerns or recommendations the Council has about the operation of the home. 2007, c. 8, s. 57 (1), 195 (4,5).
7. Provide advice and recommendations to the licensee regarding what the residents would like to see done to improve care or the quality of life in the home. 2007, c. 8, s. 57 (1), 195 (4,5).
8. Report to the Director any concerns and recommendations that in the Council's opinion ought to be brought to the Director's attention. 2007, c. 8, s. 57 (1), 195 (4,5).
9. Review,
i. inspection reports and summaries received under section 149,
ii. the detailed allocation, by the licensee, of funding under this Act and the Local Health System Integration Act, 2006 and amounts paid by residents,
iii. the financial statements relating to the home filed with the Director under the regulations or provided to a local health integration network, and
iv. the operation of the home. 2007, c. 8, s. 57 (1), 195 (4,5).
9. Review,
i. inspection reports and summaries received under section 149,
ii. the detailed allocation, by the licensee, of funding under this Act and the Local Health System Integration Act, 2006 and amounts paid by residents,
iii. the financial statements relating to the home filed with the Director under the regulations or provided to a local health integration network, and
iv. the operation of the home. 2007, c. 8, s. 57 (1), 195 (4,5).
10. Exercise any other powers provided for in the regulations. 2007, c. 8, s. 57 (1), 195 (4,5).

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. It was noted in the back of the Residents' Council Meeting minutes binder, that is kept in the Life Enrichment Coordinator's office, 3 sealed envelopes addressed to the President Of Residents' Council with the home's address on them. The Envelopes were postmarked 2012-02-22, 2012-03-15, and 2012-03-22 and were from the Ministry of Heath and Long Term Care Performance Improvement and Compliance Branch, London Service Area Office. A representative of Residents' Council was shown these envelopes and confirmed that he/she has never been given this mail to open. Inspector # 155 showed the representative a letter and an inspection report from the MOHLTC LSAO that was in the binder that was dated November 7, 2011. The representative of the Residents' Council confirmed that he/she has never seen these reports and that they have not been shared at Residents' Council meetings. The Life Enrichment Coordinator confirmed that the unopened mail has not been given to the Residents' Council representative and previous inspection reports have not been shared with Residents' Council. [s. 57. (1) 9. i.]

2. A review of the Residents' Council meeting minutes dated May 8, 2012 included the response to the Council concerns expressed at the April 10, 2012 meeting. Review of concerns/recommendations expressed at the September 11, 2012 meeting were not responded to until October 9, 2012. Review of concerns/recommendations expressed at the October 9, 2012 meeting have not been responded to as of October 25, 2012. A Residents' Council representative confirmed that they do not get a response to concerns or recommendations in writing within 10 days. [s. 57. (2)]

3. A review of Food Committee minutes for September revealed that the Administrator responded to concerns. The response was dated September 11, 2012 but the Administrator did not commence employment until September 17, 2012. He acknowledged that the date on the response was an error and confirmed that Residents' Council did not receive the response within the required 10 days because the response was actually written on October 24, 2012. [s. 57. (2)]

WN #32: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. There is no documented evidence that the licensee responds in writing within 10 days of receiving Family Council advice related to concerns or recommendations and this was confirmed by the Resident and Family Services Coordinator. [s. 60. (2)]

WN #33: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. There is no documented evidence that a mission statement is posted and communicated.
This was confirmed by the Resident and Family Services Coordinator and Administrator.
The Office Manager shared that the home does not have a mission statement and that the previous mission, vision and values statements were removed approximately 3 Administrators ago. [s. 79. (3) (b)]

2. There is no documented evidence that the name and telephone number of the licensee is posted and communicated.
This was confirmed by the Resident and Family Services Coordinator. [s. 79. (3) (h)]

3. A review of the Mandatory Reporting Information Binder, revealed that the May 2, 2012 inspection report was not posted. Both the Licensee Report and the Public Report were in a binder in the Administrator's office. This was confirmed by the Administrator. [s. 79. (3) (k)]

WN #34: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (2) A licensee shall make every reasonable effort to act on the results of the survey and to improve the long-term care home and the care, services, programs and goods accordingly. 2007, c. 8, s. 85. (2).

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

Findings/Faits saillants :

1. During an interview with the Life Enrichment Coordinator, it was revealed that the major issues identified in the October 2011 residents' satisfaction survey were:

(1) Laundry, missing clothing, not processed promptly.
A new labeling form and procedure was to be implemented by October 15/12, to avoid any mislabeling, missing clothing and label on time. There is no documented evidence of a new labeling form and procedure implemented and this was confirmed by the Environmental Services Supervisor on November 6, 2012 at 10:45 am.

(2) Food service, temperatures, look of meals, overall satisfaction
An In-service to enforce with dietary aides the need to ensure the food is plated in a manner that is attractive was determined to be needed. The Food Service Supervisor confirmed that there was no documented evidence to support that the in-service occurred.

(3) Fire Safety
Post signage on the back of each door notifying residents what to do in the event of a fire. November 5, 2012 at 12:30 pm – Inspector # 137 observed that there was no signage posted on the back of any resident bedroom doors in Kent, Elgin and Oxford. The Staff Educator, confirmed this.
Family Council was informed of Fire Procedures at the October 3, 2012 meeting by the Staff Educator. The Residents' Council and residents have not been informed of Fire Procedures in the home, as confirmed by the Staff Educator.
The Environmental Services Supervisor, Food Service Supervisor, Life Enrichment Coordinator and Staff Educator all confirmed that results of the survey have not been acted upon, except for the Family Council being informed of the home's Fire Procedure. [s. 85. (2)]

2. Evidence of non-compliance is captured in # 4. [s. 85. (3)]

3. Evidence of non-compliance is captured in # 4. [s. 85. (3)]

4. There is no documented evidence that the home seeks the advice of the Residents' Council and Family Council in developing and carrying out the survey and acting on its' results. This was confirmed by interviews with the President of the Residents' Council by Inspector # 155 and with the Family Council President by Inspector # 137. The Satisfaction Survey is developed externally by Rice and Associates, delivered to

the home, distributed by the home and returned, in postage paid envelopes, directly to Rice and Associates for review and tallying of results.
This was confirmed by the Life Enrichment Coordinator. [s. 85. (3)]

WN #35: 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. There is no documented evidence that the licensee has ensured that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences. This was confirmed by the Director of Care and, as evidenced, by the current policy in the home being dated May 2007. The Co-DOC confirmed that this was the most up-to-date policy in the home, as well as the most current online policy. [s. 99. (b)]

WN #36: The Licensee has failed to comply with O.Reg 79/10, s. 118.
Information in every resident home area or unit
Every licensee of a long-term care home shall ensure that the following are available in every resident home area or unit in the home:
1. Recent and relevant drug reference materials.
2. The pharmacy service provider's contact information.
3. The contact information for at least one poison control centre or similar body. O. Reg. 79/10, s. 118.

Findings/Faits saillants :

1. Observation by Inspector # 155 revealed that there was no documented evidence of any recent and relevant drug reference materials or the contact information of at least one Poison Control Centre in the Lambton home area. A Registered Practical Nurse confirmed that there was no drug reference materials or contact information of a Poison Control Centre on the Lambton home area. [s. 118.]

WN #37: The Licensee has failed to comply with O.Reg 79/10, s. 228.
Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. A review of the Family Council Update of June 6, 2012 revealed that the Family Council was informed of additional RPN hours, GPA Training and planned P.I.E.C.E.S Training.
There is no documented evidence that the Residents' Council was informed of these improvements and this was confirmed by the Life Enrichment Coordinator. [s. 228. 3.]

2. There is no documented evidence that the home maintains a record setting out the improvements made to the quality of the accommodation, care services, programs and goods provided residents and this was confirmed by the Administrator and Director of Care. [s. 228. 4. i.]

Issued on this 18th day of December, 2012

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

Marian L. MacDonald