Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARGOT BURNS-PROUTY (106)
Inspection No. / No de l'inspection :	2012_051106_0017
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Jun 26, 27, 28, Jul 5, 6, 25, 26, 2012
Licensee / Titulaire de permis :	BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA 1220 Valley Drive, KENORA, ON, P9N-2W7
LTC Home / Foyer de SLD :	PINECREST 1220 VALLEY DRIVE, KENORA, ON, P9N-2W7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	KEVIN QUEEN

To BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The Licensee shall prepare, submit and implement a plan to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, specifically, as related to the use of bedrails. The plan is to be submitted in writing to Long Term Care Home Inspector Margot Burns-Prouty, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 603, Sudbury, P3E 6A5, by July 16, 2012.

Grounds / Motifs :

1. The plan of care for a resident was reviewed and it identifies, "During each nap, and at HS, apply 2 bed rails for safety." According to a critical incident report submitted to the Ministry, the resident fell out of bed and was transferred to hospital due to injury sustained from the fall. Staff member S-103, reported to inspector 106 that the bed rails had been removed from the resident's bed as a result of a memo dated June 26, 2012, which directed all staff that residents who are cognitively impaired are not to use bed rails. Inspector 106 reviewed health care record for this resident and no assessment to support the removal of the bed rails was found. Staff member #S-103 informed inspector 106 that staff were directed to lower the resident's bed and use floor mats, however, the home does not have enough mats to replace the bedrails removed/discontinued on June 26, 2012 and the staff chose to place the one floor mat that was available on the side that the resident did not fall from. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (7)] (106)
2. The plan of care for a resident was reviewed and no documentation was found to indicate that bed rails were to be used for this resident. According to a critical incident report, submitted to the Ministry, the resident was found entrapped by the bed rail. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (7)] (106)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 03, 2012

Order # / Ordre no : 902

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The Licensee shall prepare, submit and implement a plan to ensure the following:
(a)that where bed rails are used all residents are assessed and his or her bed system is evaluated in accordance with evidence based practices and, if there are none, in accordance with prevailing practices, to minimize risks to residents"
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.
The plan is to be submitted in writing to Long Term Care Home Inspector Margot Burns-Prouty, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 603, Sudbury, P3E 6A5, by July 16, 2012

Grounds / Motifs :

1. According to a critical incident report submitted to the Ministry, a resident was found by staff entrapped by a bed rail, no documentation was found in the resident's health care record or plan of care to indicate that bed rails were to be used for this resident. There was no documentation found in health care record to indicate that the resident had a bed rail assessment prior to use of bed rails. The licensee failed to ensure that where bed rails are used the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident. [O. Reg. 79/10, s. 15 (1) (a)] (106)
2. According to a critical incident report, submitted to the Ministry, a resident, fell from their bed and sustained injuries, on June 27, 2012 at 0300 h. During an interview on June 27, 2012, with inspector 106, staff member # S-103 stated that the resident fell from their bed due to the bed rails not being used as per a memo received June 26, 2012 from management. On June 28, 2012, inspector 106 observed the resident asleep in bed with 2 full bed rails in the up position. Inspector 106 asked staff members #S-103 and S-104 if the resident had been assessed to determine their requirements for use of bed rails, staff member S-104 stated that, "they have the assessments ready, but they have not been completed". The licensee failed to ensure that where bed rails are used the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident. [O. Reg. 79/10, s. 15 (1) (a)] (106)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 03, 2012

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

The written request for review must be served personally, by registered mail, or by fax upon:

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto ON M5S 2B1
Fax: (416) 327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal more about the HSARB on the website www.hsarb.on.ca.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire d
celui où lui a été signifié l'avis de décision du directeur, faire parve

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

La Commission accusera réception des avis d'appel et transmettra
permis peuvent se renseigner sur la Commission d'appel et de rév

The written request for review must be served personally, by registered mail, or by fax upon:

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto ON M5S 2B1
Fax: (416) 327-7603

Issued on this 26th day of July, 2012

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : MARGOT BURNS-PROUTY

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 26, 27, 28, Jul 5, 6, 25, 26, 2012	2012_051106_0017	Critical Incident

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA
1220 Valley Drive, KENORA, ON, P9N-2W7

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

PINECREST
1220 VALLEY DRIVE, KENORA, ON, P9N-2W7

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

MARGOT BURNS-PROUTY (106)

Inspection Summary/Résumé de l'Inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Physiotherapist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Residents

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home, reviewed resident health care records

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Falls Prevention

Responsive Behaviours

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The plan of care for a resident identifies that they use a Broda chair and requires staff assistance to porter them. On June 27, 2012, inspector 106 observed the resident in a wheelchair and was seen to self propel short distances. Staff member #S-105 and #S-106 both reported to inspector 106 that the resident, no longer uses a Broda Chair and is able to self propel in a wheelchair. The licensee failed to ensure that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (10) (b)] (106)
2. The plan of care for a resident was reviewed and no documentation was found to indicate that bed rails were to be used for this resident. According to a critical incident report submitted to the Ministry, this resident was found entrapped by the bed rail. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (7)] (106)
3. The plan of care for a resident was reviewed and identifies, "During each nap, and at HS, apply 2 bedrails for safety." According to a critical incident report submitted to the Ministry, the resident fell out of bed and was transferred to hospital due to injury sustained from the fall. Staff member S-103, reported to inspector 106 that the bed rails had been removed from the resident's bed as a result of a memo dated June 26, 2012, which directed all staff that residents who are cognitively impaired are not to use bed rails. Inspector 106 reviewed health care record for this resident and no assessment found to support the removal of the bed rails were found. Staff member #S-103 informed inspector 106 that staff were directed to lower the resident's bed and use floor mats, however, the home does not have enough mats to replace the bedrails removed/discontinued on June 26, 2012 and the staff chose to place the one floor mat that was available on the side that the resident did not fall from. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (7)] (106)

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. According to a critical incident report, submitted to the Ministry, a resident, fell from their bed and sustained injuries, on June 27, 2012 at 0300 h. During an interview on June 27, 2012, with inspector 106, staff member # S-103 stated that the resident fell from their bed due to the bed rails not being used as per a memo received June 26, 2012 from management. On June 28, 2012, inspector 106 observed the resident asleep in bed with 2 full bed rails in the up position. Inspector 106 asked staff members #S-103 and S-104 if the resident #006 had been assessed to determine their requirements regarding bed rails, staff member S-104 stated that, "they have the assessments ready, but they have not been completed". The licensee failed to ensure that where bed rails are used the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident. [O. Reg. 79/10, s. 15 (1) (a)] (106)
2. According to a critical incident report submitted to the Ministry, a resident was found by staff entrapped by the bed rail. Inspector 106 reviewed the resident's health care record including plan of care, nothing found in health care record or plan of care to indicate that bed rails were to be used for this resident. There was no documentation found in health care record to indicate that the resident had a bed rail assessment prior to use of bed rails. The licensee failed to ensure that where bed rails are used the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident. [O. Reg. 79/10, s. 15 (1) (a)] (106)

Additional Required Actions:

CO # - 902 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

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.
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.
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.
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. On June 26, 2012, inspector 106 requested to see the written description of the home's Continence Care and Bowel Management Program. Staff member S-102 provided a policy titled "Continence Assessment and Care" and a "Resident Incontinence Assessment Product Request" form. These documents do not include a written description of the program's goals and objections, methods to monitor outcomes, or provide for the referral of residents to specialized resources where required. The licensee failed to ensure that there is a written description of the Continence Care and Bowel Management Program 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) (1)] (106)
2. On June 26, 2012, inspector 106 requested to see the written description of the home's Falls Prevention and Management Program. Staff member S-102 provided two policies titled, "Incident Reporting – Resident Incidents, Falls" and "Safety and Security of Residents – Nursing Responsibilities", as well as a printed power point presentation titled "Prevent a Fall". These documents do not include a written description of the program's goals and objections, methods to monitor outcomes, or provide for the referral of residents to specialized resources where required. The licensee failed to ensure that there is a written description of the Falls Prevention and Management Program 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) (1)] (106)

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 written description of the Falls Prevention and Management Program and the Continence Care and Bowel Management Program, that includes goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcome, including protocols for the referral of residents to specialized resources where required, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(c) a written record is kept relating to each evaluation under clause (b) 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. 53 (3).

Findings/Faits saillants :

1. On June 26, 2012, inspector 106 requested to see the written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers in regards to responsive behaviours. Staff member S-102 provided two policies titled, "Behaviour Charting" and "Secure Unit", as well as a printed educational power point presentation titled,"Managing Physical Aggression". These documents did not include written approaches regarding screening protocols, reassessment and the identification of behavioural triggers that may result in responsive behaviours. The licensee failed to ensure that the following are developed to meet the needs of residents with responsive behaviours: written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. [O. Reg. 79/10, s. 53 (1) 1] (106)
2. On June 29, 2012, inspector 106 asked staff member S-102, if there was a written record regarding the annual evaluation for the Responsive Behaviour Program. Staff member S-102 stated "no" and explained, that a policy has been drafted regarding this but, it is has not currently been approved. The licensee failed to ensure that a written record is kept relating to each evaluation of the Responsive Behaviours Program 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. 53 (3) (c)] (106)

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 ensure that the following are developed to meet the needs of residents with responsive behaviours: written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other and a written record is kept relating to each evaluation of the Responsive Behaviours Program 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. On June 28, 2012, at approximately 1500, inspector 106 observed a resident had chin whiskers in excess of 1.5 cm. The licensee failed to ensure that the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was fully respected and promoted. [LTCHA, 2007, S. O. 2007, c. 8, s. 3 (1) 4] (106)
2. On June 28, 2012, at approximately 1455h, a resident, indicated to inspector 106 that they needed to go to the washroom. Inspector 106, who was standing at the unit 1 nursing station, told this to 3 PSWs who were also at the nursing station. The PSWs continued to discuss their work load distribution for approximately another 3 minutes, before dispersing. At approximately 1500h, the resident signaled the inspector to come over to them and they stated that they had to go to the washroom "badly". The inspector told the resident that she had informed the staff and they should be able to help her shortly. Two of the three PSWs saw the inspector talking to the resident and they told the resident that the third PSW would help them. The third PSW came to assist the resident shortly after that and assisted the resident to the washroom. The licensee failed to ensure that the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was fully respected and promoted. [LTCHA, 2007, S. O. 2007, c. 8, s. 3 (1) 4] (106)
3. On June 27, 2012, inspector 106 observed a resident sitting near the unit 1 nursing station, with a large amount of food crumbs and debris on the front of their shirt and pants. The resident was observed to attempt to brush the crumbs off of their pants, resulting in spreading the crumbs out over a larger area. Between 1450h and 1504h, 3 RPNs and one other staff members interacted with the resident but did not assist them in removing the debris from the front of their shirt and pants. The licensee failed to ensure that the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was fully respected and promoted. [LTCHA, 2007, S. O. 2007, c. 8, s. 3 (1) 4] (106)

Issued on this 27th day of July, 2012

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