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

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) :	LAUREN TENHUNEN (196)
Inspection No. / No de l'inspection :	2012_104196_0025
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Aug 13, 14, 15, 16, 17, 30, Oct 21, 22, 23, 24, 2012
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	ROSEVIEW MANOR 99 SHUNIAH STREET, THUNDER BAY, ON, P7A-2Z2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JOANNE LENT

To REVERA LONG TERM CARE INC., 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 : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to all residents as specified in the plan.

Grounds / Motifs :

1. On August 15, 2012 at 1000hrs, the inspector observed resident #002 sitting in the dining room in a wheelchair without a chair alarm in place. The kardex was reviewed and included the intervention of chair alarm/bed alarm. Interview was conducted with staff member #S100 regarding the fall prevention strategies in place for resident #002 and they stated the resident "uses a chair and a bed alarm". When it was determined, based on observations with the inspector, that there was no chair alarm in place, staff member #S100 put one on the wheelchair. The resident's plan of care, specifically the kardex, identified the use of a chair alarm on resident #002's wheelchair, although this was not provided on August 15, 2012.

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).] (196)

2. A Critical Incident was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in October 2011 for a resident fall with injury and transfer to hospital which had occurred in October 2011. According to the report, resident #002 had an unwitnessed fall at the bedside which resulted in serious injury and subsequent transfer to hospital. The report identified the bed alarm was not activated or connected and therefore did not alert staff that the resident was getting out of bed. Interview was conducted with staff member #S101 and it was confirmed the bed alarm was in place but had not been activated. The licensee did not ensure the resident's bed alarm was activated as was included in the resident's plan of care.

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).] (196)

3. A Critical Incident was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in May 2012 outlining a resident fall with serious injury requiring transfer to hospital, which had occurred in May 2012. According to the report, resident #007 was in their wheelchair changing their own clothing for the night when the resident undid the seatbelt in the wheelchair and fell. The one staff member that was present at the time, turned to see the resident when the chair alarm sounded and was unsure if the resident had actually fallen or threw themselves out of the chair. The RAI-MDS dated April 11, 2012, identified the resident as having "total dependence - two+ persons physical assist" for dressing. The kardex dated April 11, 2012 under category of "dressing" indicated resident #007 was "total dependence with 2+ person physical assist". The licensee failed to ensure the resident was provided with total assistance with dressing at the time of the fall with injury.

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).] (196)

4. On August 14,2012 at 0925hrs, the inspector observed resident #009 sitting upright in their bed with a breakfast tray in reach. The tray contained a plate of sliced tomatoes and bun and an empty cup of coffee. A staff member was not present with the resident to monitor and no staff were observed in the corridor outside the

resident's room. The care plan with review date of June 21, 2012 under the focus of "eating", the interventions include - regular diet, minced - set up assistance only, provide supervision, "stays and eat in their room for light breakfast, which they often refused, as per family and their request with one staff supervision. Has been eating in room with family members for supper". Resident #009's care plan specifies the supervision of one staff for the breakfast meal that is eaten in the resident's room. The licensee did not ensure that supervision was provided to the resident during the breakfast meal as specified in the care plan.

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. 2007, c. 8, s. 6 (7). (196)

5. A Critical Incident was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in February 2012 for a resident fall with injury and transfer to hospital which had occurred in February 2012. According to the report, resident #005 was in the shower room standing with a walker in front of a mirror combing their hair, lost their balance and subsequently fell back and sustained injury. An interview was conducted with staff member #S101 and it was reported that the staff member present at the time of the shower had turned their back for a moment and the resident then fell backwards. The care plan for resident #005 identified the resident at risk for falls and required a one person physical assist with personal hygiene. The staff member that was present with resident #005 in the shower did not provide care as set out in the plan of care, specifically one person physical assist with personal hygiene.

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).] (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 14, 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
1075 Bay Street, 11th Floor
Toronto ON M5S 2B1
Fax: (416) 327-7603

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

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

Health Services Appeal and Review Board and the

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

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

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

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 :

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

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

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

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

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

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 24th day of October, 2012

Signature of Inspector / Signature de l'inspecteur : Lauren Tenhunen #196

Name of Inspector / Nom de l'inspecteur : Lauren Tenhunen

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
Aug 13, 14, 15, 16, 17, 30, Oct 21, 22, 23, 24, 2012	2012_104196_0025	Critical Incident

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

ROSEVIEW MANOR
99 SHUNIAH STREET, THUNDER BAY, ON, P7A-2Z2

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

LAUREN TENHUNEN (196)

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 the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents

During the course of the inspection, the inspector(s) conducted a tour of all resident care areas, observed the provision of care and services to residents of the home, reviewed the health care records of various residents, reviewed various home policies and procedures, reviewed the Critical Incident reports submitted to the Ministry of Health and Long-Term Care (MOHLTC)

Ministry of Health and Long-Term Care (MOHLTC) Log #'s: S-000272-12,S-001825-11,S-000644-12,S-000700-12,S-000271-12,S-000487-12,S-000706-12

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

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 subsections:

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

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

Findings/Faits saillants :

1. A Critical Incident was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in February 2012 for a resident fall with injury and transfer to hospital, which had occurred in February 2012. According to the report, resident #005 was in the shower room standing with a walker in front of a mirror combing their hair, lost their balance and subsequently fell back and sustained an injury. An interview was conducted with staff member #S101 and it was reported that the staff member present at the time of the shower had turned their back for a moment and the resident then fell backwards. The care plan for resident #005 identified the resident was at risk for falls and required a one person physical assist with personal hygiene. The staff member that was present with resident #005 in the shower did not provide care as set out in the plan of care, specifically one person physical assist with personal hygiene.

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).]

2. On August 16, 2012, resident #005 was observed sleeping in bed with the wheelchair at the bedside and no bed alarm in place. On August 17, 2012 at 1315hrs, the inspector observed resident #005 self transferring to the toilet in their washroom. The chair alarm was not observed to be on the wheelchair and the alarm apparatus was found to be in the bedside table. An interview was conducted with staff member #S104 on August 17, 2012 and it was confirmed that the bed and chair alarm are used for this resident, as they are a fall risk. Staff member #S106 also reported the resident has a chair and bed alarm. Inspector reviewed the care plan and kardex for resident #005 with a review date of May 31, 2012 and neither document includes the use of either a chair or bed alarm.

The licensee failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. [LTCHA 2007,S.O.2007, c. 8, s. 6 (1)(c).]

3. On August 14,2012 at 0925hrs, the inspector observed resident #009 sitting upright in their bed with a breakfast tray within reach. The tray contained a plate of sliced tomatoes and bun and an empty cup of coffee. A staff member was not present with the resident to monitor and no staff were observed in the corridor outside the resident's room. The care plan with review date of June 21, 2012 under the focus of "eating", interventions include - regular diet, minced - set up assistance only, provide supervision, "stays and eat in their room for light breakfast, which they often refused, as per family and their request with one staff supervision. Has been eating in room with family members for supper". Resident #009's care plan specifies the supervision of one staff for the breakfast meal that is eaten in the resident's room. The licensee did not ensure that supervision was provided to the resident during the breakfast meal as specified in the care plan.

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).]

4. A Critical Incident was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in May 2012 outlining a resident fall with serious injury requiring transfer to hospital which had occurred in May 2012. According to the report, resident #007 was in their wheelchair changing their own clothing for the night when the resident undid the seatbelt in the wheelchair and fell. The one staff member that was present at the time, turned to see the resident when the chair alarm sounded and was unsure if the resident had actually fallen or threw themselves out of the chair. The RAI-MDS dated April 11, 2012, identified the resident as having "total dependence - two+ persons physical assist" for dressing. The kardex dated April 11, 2012 under category of "dressing" indicated resident #007 was "total dependence with 2+ person physical assist". The licensee failed to ensure the resident was provided with total assistance with dressing at the time of the fall with injury.

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).]

5. A Critical Incident was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in October 2011 for a resident fall with injury and transfer to hospital which had occurred in October 2011. According to the report, resident #002 had an unwitnessed fall at the bedside which resulted in serious injury and subsequent transfer to hospital. The report identified the bed alarm was not activated or connected and therefore did not alert staff that the resident was getting out of bed. Interview was conducted with staff member #S101 and it was confirmed the bed alarm was in place

but had not been activated. The licensee did not ensure the resident's bed alarm was activated as was included in the resident's plan of care.

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).]

6. On August 15, 2012 at 1000hrs, the inspector observed resident #002 sitting in the dining room in a wheelchair without a chair alarm in place. The kardex was reviewed and included the intervention of chair alarm/bed alarm. Interview was conducted with staff member #S100 regarding the fall prevention strategies in place for resident #002 and they stated the resident "uses a chair and a bed alarm". When it was determined, based on observation with the inspector, that there was no chair alarm in place, staff member #S100 put one on the wheelchair. The resident's plan of care, specifically the kardex, identified the use of a chair alarm on resident #002's wheelchair, although this was not provided on August 15, 2012.

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).]

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 O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. Inspector conducted a walk through of resident care areas on August 14, 2012 at 0950hrs. The resident care cart on a unit was observed to contain an unlabelled used deodorant and an unlabelled hair brush and comb. In addition, a spa room had an unlabelled comb and hairbrush that were found beside the sink along with two pairs of unlabelled nail clippers. Inspector observed another spa room and noted two unlabelled combs and two unlabelled used deodorants.

The licensee failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring, in the case of new items; [O. Reg. 79/10, s. 37 (1)(a).]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. On August 14,2012 at 0925hrs, the inspector observed resident #009 sitting upright in their bed with a breakfast tray within reach. The tray contained a plate of sliced tomatoes and bun and an empty cup of coffee. A staff member was not present with the resident to monitor and no staff were observed in the corridor outside the resident's room. The care plan with review date of June 21, 2012 under the focus of "eating", interventions include - regular diet, minced - set up assistance only, provide supervision, "stays and eat in their room for light breakfast, which they often refused, as per family and their request with one staff supervision. Has been eating in room with family members for supper". Interview conducted with the staff member #S101 on August 16, 2012 and it was reported that the home's policy is that residents are to have staff/family supervision with meals and snacks provided by the home. The licensee did not ensure that resident #009 was monitored during the breakfast meal on August 14, 2012.

The licensee failed to 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)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 that ensures the dining and snack service includes the monitoring of all residents during meals, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. On August 16, 2012, resident #003 was observed not to have the call bell within reach between the hours of 1330 and 1525hrs. Inspector observed the call bell on the other side of the resident's bed and not within reach of the resident while they were seated in a chair. Staff member #S102 confirmed that the call bell was not within reach of the resident and stated "the call bell is to be within her reach" and acknowledged the resident can use it without difficulty.

The licensee failed to 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)(a)]

Issued on this 24th day of October, 2012

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

Lauren Lehmann #196.