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 prévue le Loi de 2007 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
Direction de l'amélioration de la performance et de la conformité

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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 23, 2015;	2015_376594_0026 (A1)	021564-15	Resident Quality Inspection

Licensee/Titulaire de permis

ANSON GENERAL HOSPITAL
58 Anson Dr. IROQUOIS FALLS ON P0K 1E0

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

SOUTH CENTENNIAL MANOR
240 FYFE STREET IROQUOIS FALLS ON P0K 1E0

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

MONIKA GRAY (594) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Changed wording in CO#005 from "but limited to", to "but not limited to" in licensee order report only.

Issued on this 23 day of December 2015 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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

MONIKA GRAY (594) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): August 31-September 04 and September 08 - September 11, 2015

This inspection includes Log #003962-14, #018773-15; S-000112-14 and #012544-15.

During the course of the inspection, the inspector(s) spoke with Residents, Substitute Decision Makers (SDM), Personal Support Workers (PSWs), Dietary Aide (DA), Housekeepers (Hskg), Maintenance staff, Recreation Therapy Lead, Registered Practical Nurses (RPNs), Registered Nurses (RN), Registered Dietitian (RD), Support Services Lead (SSL), Director of Support Services, Acting Director of Care (ADOC), Chief Nursing Officer (CNO) and the Administrator/Director of Care (DOC).

The inspector(s) also reviewed policies, plans of care and other documentation within the home, conducted a daily walk through of the resident care areas, observed staff to resident interactions and the delivery of care and services to the residents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Critical Incident Response

Dining Observation

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

25 WN(s)
12 VPC(s)
5 CO(s)
1 DR(s)
0 WAO(s)

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. 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. (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. The licensee has failed to ensure that the written plan of care for resident #016 set out clear directions to staff and others who provided direct care to the resident.

During a family interview with Inspector #594, the Substitute Decision Maker (SDM) of resident #016, stated that the resident had a responsive behaviour upon admission, continued with the behaviour, and had exhibited another responsive behaviour multiple times since admission. The resident was provided a device, but the SDM stated that many times the device would not work.

Inspector #594 and #575 met with the Assistant Director of Care (ADOC) and the Chief Nursing Officer (CNO) regarding the high risk concerns of resident #016's repeated responsive behaviours. At the Inspectors' request, a plan was immediately developed which indicated that an additional device was applied to resident #016, and an intervention was to be completed on resident #016.

Inspector #594 reviewed the resident's health care record. The care plan indicated the use of one device with two different identification numbers and to document an intervention at a certain time interval. The inspector reviewed additional charting in

resident #016's health care record which indicated that staff were to document the intervention at different time intervals.

An interview was conducted with PSW #119. They indicated that staff were to document an intervention at a certain time interval for resident #016. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care, was provided to the resident as specified in the plan.

On September 02, 04, and 08, 2015, Inspector #575 observed resident #011's room and noted two bed rails in the up position (the resident was not in bed). On September 09, 2015, the inspector observed resident #011 in bed with the same bed rail configuration.

During an interview with the Inspector, RPN #121 confirmed that the resident had two bed rails up.

The inspector reviewed the resident's most recent electronic care plan which indicated that the resident required one bed rail up to assist them to reposition. [s. 6. (7)]

3. During a family interview with Inspector #594, the SDM of resident #016, had stated that the resident had a responsive behaviour upon admission, continued with the behaviour, and had exhibited another responsive behaviour multiple times since admission. The resident was provided a device, but the SDM stated that many times the device would not work.

Inspector #594 reviewed the resident's care plan which documented the use of a device and had directed staff once a shift, to ensure that the device was worn by the resident and functioning.

An interview was conducted with PSW #119. They indicated they did not check the functionality of the device.

An interview was conducted with RPN #104. They stated that staff checked to make sure the resident was wearing the device but did not check if it was functioning.

An interview was conducted with the Administrator/Director of Care. They stated that checks on the device had not been documented but staff should have been checking. [s. 6. (7)]

4. The licensee has failed to ensure that resident #016's plan of care was reviewed and revised at any time when care set out in the plan had not been effective.

During a family interview with Inspector #594, the SDM of resident #016, had stated that the resident had a responsive behaviour upon admission, continued with the behaviour, and had exhibited another responsive behaviour multiple times since admission. The resident was provided a device, but the SDM stated that many times the device would not work.

On September 02, 2015, at 1000 hours, Inspector #594 observed resident #021 trying to minimize resident #016's responsive behaviour.

On September 02, 2015, at 1800 hours, Inspector #594 and #575 observed resident #016 and a second resident exhibit responsive behaviours. Resident #016 was observed by the inspectors to exhibit responsive behaviours. During this same observation, resident #021 was trying to minimize resident #016's responsive behaviour. The inspectors observed that after a period of time a staff member arrived to respond to resident #016's responsive behaviour.

Inspector #594 and #575 met with the ADOC and the CNO regarding the high risk concerns of resident #016's responsive behaviour. At the Inspectors' request, a plan was immediately developed by the ADOC and CNO.

During an interview with the inspector, the CNO indicated that there was a frequent visitor (Visitor #200) to the home who had contributed to the resident's responsive behaviours.

An interview was conducted with RN #103. They stated that resident #016 exhibited a responsive behaviour because visitor #200 would contribute to the resident's responsive behaviours. RN #103 stated to the inspector that staff were aware that they must respond as quickly as possible when resident #016 was exhibiting responsive behaviours but they had very limited staff in the evening (two registered staff and three direct care staff) and that it was difficult to respond quickly.

On September 10, 2015, at 1744 hours Inspector #594 observed visitor #200 contribute to a resident's responsive behaviours.

An interview was conducted with RN #101 who stated that a few weeks prior a family

member of another resident contributed to resident #016 responsive behaviour. A month prior another visitor to the home contributed to resident #016's responsive behaviour. RN #101 further stated to the inspector that there is not enough staff at night because registered staff must ensure medications were locked and direct care staff must ensure the residents they were assigned to care for were safe before attending to such responsive behaviour incidents.

The inspector reviewed the resident's progress notes and found that during one year, 27 documented entries of the resident having responsive behaviours and 15 documented entries of the resident exhibiting another responsive behaviour. The inspector further noted the device was changed in 2015 when staff observed the device not functioning.

During a month in 2015, it was documented that on five occasions the device did not function.

Inspector #594 reviewed resident #016's most recent electronic care plan which stated a focus of a responsive behaviour problem and listed interventions.

Inspector #594 reviewed the home's Responsive Behaviour Resident Care policy #R-45 last date reviewed May 3, 2013, which documented that the plan of care was resident focused and the care plan must include description of the responsive behaviour/condition; level of risk and to whom; identified triggers/causes of behaviour; interventions, strategies and techniques; objectives of the interventions; medication regime and reassessment time frames.

During interviews with the inspector RN #101, RN #103, RPN #117 and PSW #118 all stated when the resident was exhibiting responsive behaviours staff would try an intervention and although this worked at times, it was very difficult to redirect the resident.

An interview was conducted with the Administrator/Director of Care. They stated resident #016's responsive behaviour trigger and that it was not identified in the plan of care.

The decision to issue this compliance order was based on the severity which indicated actual risk of resident #016's responsive behaviour because the care plan failed to provide updated interventions past a month in 2014 that had been effective. Although the scope was isolated, there is a history of non-compliance with s. 6 of the LTCHA,

2007. A Voluntary Plan of Correction was issued during Critical Incident Inspection 2013_138151_0029 and during Resident Quality Inspection 2014_282543_0025. [s. 6. (10) (c)]

Additional Required Actions:

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

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care for resident #016 provides clear direction specifically to how often an intervention is completed and which device is being used, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

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

minimize risk to the resident.

A) On September 02, 04, and 08, 2015, Inspector #575 observed two bed rails in the up position on resident #011's bed (the resident was not in bed).

On September 09, 2015, the inspector observed the same rails in the up position and the resident in bed.

An interview was conducted with RPN #106. They indicated that the resident used the bed rails to assist with mobility in bed.

B) On September 02, 04, and 08, 2015, Inspector #575 observed one bed rail in the up position on resident #010's bed (the resident was not in bed).

On September 10, 2015, the inspector observed two bed rails in the up position and the resident in bed.

An interview was conducted with PSW #109. They indicated that the resident used two bed rails when in bed for safety and bed mobility.

The inspector reviewed the home's 'Bed Entrapment Prevention Program' dated July 2015, which was provided by the Administrator/Director of Care. Attached to the document was a memo dated September 08, 2015, to RN's, RPN's, and PSW's regarding bed entrapment and bed rails with a bed rail risk assessment form attached. The document indicated that each resident would have a formal bed rail risk assessment on admission and be reassessed on readmission, at significant changes in condition and following any incident related to safety in bed. The document further indicated that the resident's electronic health record should have included a bed rail risk assessment.

An interview was conducted with the Administrator/Director of Care. They confirmed that registered staff were to complete the bed rail risk assessment for each resident and that the assessments were not completed as planned.

The inspector noted that during an inspection conducted in October 2014 (#2014_282543_0025), the home was issued a written notification (WN) for the same non-compliance (NC). On February 18, 2015, the home submitted a plan that indicated all beds were scheduled to be assessed during a week in 2015. [s. 15. (1) (a)]

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

On September 02, 2015, Inspector #575 observed two maintenance staff conducting bed entrapment assessments.

Inspector #575 reviewed completed bed entrapment assessments and noted that 14/71 beds or 20% failed some, or a combination, of zones 1,2,3 and 4.

On September 09, 2015, the inspector requested from the Administrator/Director of Care, the home's plan to address the entrapment risks associated with the beds which failed the entrapment tests. The Administrator/Director of Care indicated that after all the resident bed rail assessments were completed, the home would order new bed rails for those that could be replaced and that some beds would need to be replaced.

Inspector #575 reviewed a Compliance Plan submitted to the Ministry of Health and Long-Term Care On February 18, 2015, that indicated all beds were scheduled to be assessed during the a week in 2015.

Inspector #575 conducted an interview with the Administrator/Director of Care. They confirmed to the inspector that bed entrapment assessments were completed five months after the scheduled date in 2015.

Inspector #594 conducted an interview with the Administrator/Director of Care on September 11, 2015, and they confirmed that no bed rail assessments had been completed on any residents, therefore, no steps were taken to prevent resident entrapment.

The decision to issue this compliance order was based on the severity which indicated the potential for actual harm specifically to residents whose bed failed the bed entrapment assessment and that no resident was assessed for use of a bed rail(s). The scope was widespread and there was previous non-compliance issued with s.15 of the O.Reg 79/10 during Inspection 2014_282543_0025. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 002 will be 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. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that training had been provided for all staff who applied physical devices or who monitor residents restrained by physical devices including the application, use and potential dangers of these physical devices.

An interview was conducted with RN #101, RPN #102, RN #103 and RPN #106.

They all stated that staff were required to complete self-directed learning from the duo-tangs in the nursing station and were to sign off and initial when they had reviewed the Restraint policy.

The inspector reviewed the 2014 restraint training records. The inspector noted that only 30/44 of required staff (68%) had completed review of the Restraint policy.

The inspector reviewed the home's Minimizing Restraining of Residents policy #R-40 last date reviewed February 20, 2013. According to the document, direct care team members must receive annual retraining on restraint policies and procedures and the correct use of equipment as it related to their job.

An interview was conducted with the Administrator/Director of Care. They stated that staff were initially trained in the application, use and potential dangers but had not completed annual training on the application of restraints and should have.

The decision to issue this compliance order was based on the severity which indicated potential for actual harm if not trained in the application, use and potential dangers. The scope was widespread, and there is a previous non-compliance with s. 221 of the O. Reg.79/10. During Resident Quality Inspection 2014_282543_0025 a Voluntary Plan of Correction was issued. [s. 221. (1) 5.]

2. The licensee has failed to ensure that training had been provided for all staff who applied Personal Assistance Service Devices (PASDs) or who monitor residents with PASDs including the application, use and potential dangers of these PASDs.

A) On September 10, 2015, the Inspector #575 observed resident #010 using a PASD.

The inspector reviewed of the resident's health care record, which revealed that staff failed to try alternatives or obtain consent to the use of a PASD for resident #010.

B) Inspector #594 observed resident #008 to have a PASD in use on September 09, 2015.

The inspector reviewed the resident's health care record, which revealed that staff failed to obtain consent for a PASD for resident #008.

An interview was conducted with RN #101, RPN #102, RN #103 and RPN #106.

They all stated there was no training related to resident use of PASDs, and that staff were required to complete self-directed learning from the duo-tangs in the nursing station and were to sign off and initial when they had reviewed the policy.

The inspector reviewed the 2014 PASD training records. The inspector noted that only 30/44 required staff (68%) had completed review of the PASD policy.

An interview was conducted with the Administrator/Director of Care. They stated that staff were initially trained in the application, use and potential dangers but had not completed annual training on the application of PASDs and should have.

The decision to issue this compliance order was based on the severity which indicated potential for actual harm if not trained in the application, use and potential dangers. The scope was widespread, and there is a previous non-compliance with s. 221 of the O. Reg.79/10. During Resident Quality Inspection 2014_282543_0025 a Voluntary Plan of Correction was issued. [s. 221. (1) 6.]

3. The licensee has failed to ensure all direct care staff received the required annual responsive behaviour training.

During a family interview with Inspector #594, the SDM of resident #016, had stated that the resident had a responsive behaviour upon admission, continued with the behaviour, and had exhibited another responsive behaviour multiple times since admission.

The inspector reviewed the resident's health care record. The care plan failed to identify the behavioural triggers for the resident's responsive behaviour.

An interview was conducted with RN #101, RPN #102, RN #103 and RPN #106. They all stated that staff were required to complete self-directed learning from the duo-tangs in the nursing station and were to sign off and initial when they had reviewed the policy.

The inspector reviewed the 2014 Responsive Behaviour training records. The inspector noted that only 30/44 required staff (68%) had completed review of the Responsive Behaviours policy.

The inspector reviewed the home's Responsive Behaviour Resident Care policy #R-45 last date reviewed May 03, 2013. The document indicated that all staff,

contractors providing direct care and volunteers must be orientated prior to assuming their job responsibilities and retrained annually in caring for persons with responsive behaviours and behaviour management.

The decision to issue this compliance order was based on the severity which indicated potential for actual harm if not trained in behaviour management. The scope was widespread, and there is a previous non-compliance with s. 221 of the O. Reg.79/10. During Resident Quality Inspection 2014_282543_0025 a Voluntary Plan of Correction was issued. [s. 221. (2)]

Additional Required Actions:

CO # - 003, 004 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of maintenance services for the home.

Inspector #594 and #575 observed all areas of the home that were identified in the compliance order issued December 18, 2014, during Resident Quality Inspection 2014

_282543_0025 and observed that many areas, and additional areas remained in a state of disrepair.

The following areas were observed in a state of disrepair by the Inspectors during the inspection:
Unit A
Utility room - baseboard flooring lifted away at corner's and along wall
Tub room: floor tile missing from left of tub, floor is lifted in some of the areas
Room 2: Wear and tear in carpet in front of window, cracked sealant around bathroom vanity
Room 4: Bathroom vanity pulled away from wall at front left corner, sealant missing around the vanity, holes at carpet door entrance
Room 5: Back of bathroom vanity top surface layer missing exposed chip board
Room 6: Front of bathroom vanity chipboard exposed and band aids applied on corners of bathroom cupboard doors
Room 8: Bathroom vanity chipboard exposed, sealant missing around vanity
Room 9: Bathroom vanity corner peeling exposed chipboard, bathroom cupboard door hinges loose (resulting in cupboard doors tilted), bathroom light covering missing
Room 10: Bathroom shared with Room 9, holes in carpet near bathroom entrance
Room 11: Sealant gone around bathroom vanity, vanity starting to pull away from wall, carpet wear at foot of bed and in front of closet

Unit B
Tub room: water damage to the flooring, stained under the tub
Room 5: Paint missing from behind toilet, white paint on blue floor under radiator, top bathroom cupboard door tilted from hinge, bathroom door had gouge on door leading into bathroom, bathroom door frame at bottom of trim scuffed up and missing paint
Room 11- hole in flooring, shared bathroom vanity drawers in disrepair exposed chip board, no cover on thermostat
Room 13- bathroom vanity drawers chipboard exposed
Room 15- drywall repair not painted in room; no fixture to cover light in shared bathroom
Room 18- paint scraped off along wall

Unit C
Tub room: linoleum had bubbled
Room 2: Scrapes along dresser bottom and front, sealant missing along front of bathroom vanity, third bathroom cupboard door hinges loose (resulted in cupboard doors tilted), radiator in bathroom scratched and missing paint, wall in room beside

door black scuff marks
Room 4: Drywall screws and holes in wall beside door, sealant missing from front of bathroom vanity
Room 5: Front of resident room door missing veneer at bottom and up alongside
Room 6: Wall scratched up under bulletin board, radiator missing paint in bathroom, wall paint missing from bathroom
Room 8: Bathroom vanity top worn with stains, and drywall/paint pulled away from wall corner, some drywall damage to right of window
Room 11: Hole in vinyl floor at foot of bed, sealant missing from bathroom vanity, bottom bathroom cupboard door tilted from hinge
Room 14: Large black water marks on ceiling above bed, some paint missing from wall opposite bed, missing veneer from front of bathroom vanity

Visitor washroom at front of home:
Large amount of calcium build up around water spout in sink resulting in green discolouration

The inspectors' list of observations as listed above in no way represented a comprehensive audit of all home areas.

On September 10, 2015, Inspector #594 and Maintenance Staff #120 toured the home. Maintenance Staff #120 confirmed the inspectors observations.

Inspector #594 reviewed the homes Maintenance Requisition Book. Over an eight month period, the inspector identified entries that documented various home areas in disrepair, such as holes in walls and floors, walls that needed paint, closet door not able to be closed. According to these same entries, maintenance responses indicated that some repairs required direction to be provided by the Director of Support Services, some entries did not have maintenance responses and one response indicated that a quote was received to repair the floor but was waiting for funding.

On September 10, 2015, an interview was conducted with Maintenance Staff #120. They stated that staff document in a requisition book, maintenance concerns including identified home areas that require repair. Maintenance staff would check the requisition book daily and complete a written maintenance response. They also indicated an electronic maintenance program was available but not used. During the same interview, Maintenance Staff #120 stated that areas such as where the sealant/caulking was cracked or missing around bathroom vanities, painting, cupboard doors not hung properly and addressing the floor in the tub rooms could be completed

without waiting for funding.

On September 11, 2015, an interview was conducted with the Administrator/Director of Care. They stated that they, the Chief Executive Officer (CEO) and Director of Support Services were aware of the identified rooms and problems, and that the home had a preventative maintenance computer program but had not seen it in use. During the same interview they stated that areas such as missing caulking/sealant and cupboard doors that were misaligned could have been fixed.

On September 15, 2015, an interview was conducted with the Director of Support Services. They stated that staff documented in a requisition book maintenance concerns including identified home areas that required repair. The home did have an electronic maintenance program that should have been used but was not being used. During the same conversation, they stated that some maintenance repair areas such as missing caulking/sealant around bathroom vanities could have been repaired and confirmed that maintenance items addressed from Inspection 2014_282543_0025 had not been repaired.

The decision to issue this compliance order was based on the severity which indicates potential for actual harm given holes in flooring and bathroom vanities in a state of disrepair. The scope was widespread, and the licensee has a history of non-compliance with s. 15 of the LTCHA, 2007. Since 2013 the section has been issued three previous times: a compliance order on May 28, 2013, during Critical Incident Inspection 2013_138151_0017; a second compliance order on October 24, 2013, during Follow Up Inspection 2013_138151_0028, a third compliance order on December 18, 2014, during Resident Quality Inspection 2014_282543_0025 with a compliance date of March 01, 2015. [s. 15. (1) (c)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 005

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #5: 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. The licensee has failed to ensure that the home's Skin and Wound Care Management Program, policy number S-30 was complied with.

Resident #012 was identified as having altered skin integrity.

The inspector reviewed the home's policy titled Skin & Wound Care Management Program policy number S-30, last revised June 19, 2012, and last reviewed February 19, 2013. The document indicated that upon discovery of a pressure ulcer, staff were to initiate a baseline assessment using a clinically appropriate assessment instrument and guided staff to use the Pressure Ulcer/Wound Assessment Record. The document further indicated that staff were to take pictures quarterly of chronic wounds, and to obtain a seating assessment if the resident had an ulcer on a sitting surface. The same policy also indicated that staff were to complete a Braden scale, head to toe, and foot assessment in MED E-care (the home does not use MED E-care and currently use Point Click Care) within 24 hours of admission to identify resident at risk for altered skin integrity.

The inspector reviewed the resident’s heath care record and noted that the Pressure Ulcer/Wound Assessment Record was not used for this resident. Quarterly pictures and a seating assessment were also not conducted for this resident.

On September 08, 2015, an interview was conducted with RPN #102. They indicated that wound reassessments were documented on the 'wound tracking form'.

On September 08, 2015, an interview was conducted with RN #103. They indicated that the Braden skin assessment was to be completed on admission and the head to toe assessment was to be completed quarterly for residents with wounds.

On September 10 and 11, 2015, an interview was conducted with the Administrator/Director of Care. They confirmed the inspectors findings that the Pressure Ulcer/Wound Assessment Record was not used for this resident and that the quarterly pictures of chronic wounds and a seating assessment were also not conducted. [s. 8. (1) (a),s. 8. (1) (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 home's Skin and Wound Care, and Pain Management Program policies are in compliance and implemented in accordance with all applicable requirements under the Act, and is complied with, to be implemented voluntarily.

WN #6: 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. The licensee has failed to ensure that the Fall Prevention, Skin and Wound, Continence Care and Bowel Management, and Pain Management Programs, were evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Inspector #575 reviewed the home's policy titled 'Fall Prevention & Management Program ADM - 615', last revised January 6, 2008, and last reviewed February 16, 2012. The policy outlined seven appendices however the inspector noted that two additional appendices were not referred to in the policy.

On September 09, 2015, an interview was conducted with the Administrator/Director of Care. They indicated that they were not sure why the additional appendices were added and confirmed that they were not referred to in the policy. During the same interview they confirmed that the post fall assessment was not included in the policy and indicated that one of the appendices listed in the policy (checklist for residents assessed based on level of risk) was not currently used by the home, that it was old, and the policy needed to be updated. [s. 30. (1) 3.]

2. During the course of the inspection, resident #012 was identified as having altered skin integrity and Inspector #575 identified that the Pressure Ulcer/Wound Assessment Record was not used for this resident.

Inspector #594 reviewed the home's interdisciplinary programs and observed that the:
• Skin & Wound Care Program: Skin & Wound Care Management Program policy #S-30 was last reviewed February 19, 2013
• Continence Care and Bowel: Continence Care and Bowel Management Program policy #C-50 was last reviewed April 2, 2013
• Pain Management: Pain Management policy #P-05 was last reviewed February 20, 2013.

An interview was conducted with the Administrator/Director of Care. They stated that the programs were not evaluated and updated at least annually. [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 for each of the interdisciplinary programs required under section 48, 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, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a PASD to assist resident #010 with a routine activity of daily living was included in a resident's plan of care only if

alternatives to the use of a PASD had been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.

Inspector #575 observed resident #010's room on September 2 and 8, 2015, and observed a PASD.

On September 10, 2015, the inspector observed the resident using a PASD.

The inspector reviewed the resident's health care record. The documents indicated that the resident required the use of PASD. The inspector was not able to find any alternatives that were considered or tried.

The inspector reviewed the home's policy titled 'Personal Assistance Service Devices (PASDs) Use of', number R-42 last reviewed February 20, 2013. According to the document staff were to consider and try alternatives to the use of a PASD.

Interviews were conducted with two staff (RPN #102 and RN #103) and the Administrator/Director of Care. They all confirmed there were no alternatives to the PASD that had been tried and found not appropriate in the resident's health care record. [s. 33. (4) 1.]

2. The licensee has failed to ensure that the use of a PASD to assist resident #008 with a routine activity of daily living was included in a resident's plan of care only if the use of the PASD had been approved by physician, RN, RPN, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations.

On September 09, 2015, the inspector observed resident #008 to have a PASD in use.

The inspector reviewed the resident's health care record. According to the record the device was a PASD. The inspector failed to locate documentation for the approval of the PASD.

The inspector reviewed the home's policy titled 'Personal Assistance Service Devices (PASDs) Use of', number R-42 last reviewed February 20, 2013. According to the document the use of a PASD was to be approved by one of the registered health care professionals identified above.

An interview was conducted with RN #103, RPN #106 and RPN #102. They all stated approval by a healthcare professional listed above was not required for a PASD and stated the device for resident #008 was considered a PASD. [s. 33. (4) 3.]

3. The licensee has failed to ensure that the use of a PASD to assist resident #008 and #010 with a routine activity of daily living included in the resident's plan of care only if it had been consented to by the resident or if the resident was incapable a substitute decision-maker with the authority to give that consent.

During a staff interview with RPN #117 it was stated to Inspector #594 that resident #008 requested the use of a PASD for assistance. Inspector #594 observed resident #008 to have a PASD in use on September 09, 2015.

During an interview with the inspector, resident #008 stated they preferred to have the PASD at night for comfort and to help them move.

The inspector reviewed the resident's care plan which documented under the focus of PASD, the PASD is used to assist resident with repositioning and as per their request. Follow PASD protocol.

Review of the Monthly Restraint Review dated during a month in 2015, by the inspector and RN #103, documented that resident #008 had a PASD.

The inspector reviewed the health care record for the resident and failed to locate documentation for the required consent for use of the PASD.

In an interview with the inspector RN #103, RPN #106 and RPN #102 stated consent was not required for a PASD and stated the PASD for resident #008 was considered a PASD. [s. 33. (4) 4.]

4. Inspector #575 observed resident #010's room on September 2 and 8, 2015, and noted a PASD (the resident was not using the PASD). On September 10, 2015, the inspector observed the resident with the PASD in use.

The inspector reviewed the resident's health care record. The most recent quarterly MDS assessment dated in 2015, indicated that the resident required extensive assistance of two staff for mobility and that the PASD was used for mobility or transfer. The resident's most recent care plan indicated that the resident used the

PASD for re-positioning and that staff were to follow the PASD protocol. The inspector was not able to find a consent for the use of the PASD.

The home's policy titled 'Personal Assistance Service Devices (PASDs) Use of', number R-42 last reviewed February 20, 2013 identified that the prescribing clinician was to obtain and record informed consent (including that the risks and benefits of alternative treatment options and risks and benefits related to the use of the PASD had been outlined to the resident/SDM).

Two staff (RPN #102 and RN #103) and the Administrator/Director of Care also confirmed there was no consent for the use of a PASD in the resident's health care record. [s. 33. (4) 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 for residents #008 and #010 and any other resident with use of a PASD: that the PASD is included in the resident’s plan of care only if it has been consented to by the resident or SDM; and to ensure that for resident #010, alternatives to the use of a PASD are considered, and tried where appropriate; and to ensure that for resident #008 the PASD has been approved by a registered health care provider as identified in the Act, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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; O. Reg. 79/10, s. 53 (3).
(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 O. Reg. 79/10, s. 53 (3).
(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).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Responsive Behaviour Program had been evaluated annually and updated in accordance with evidence-based practices or prevailing practices.

The inspector reviewed the home's Responsive Behaviour Resident Care policy #R-45 last date reviewed May 03, 2013, which documented that the home's policy and practices were to be evaluated and updated at least annually in keeping with evidence based practices or if there are none, prevailing practices.

An interview was conducted with the Administrator/Director of Care. They stated that not all policies and programs had been updated and revised and that the dates listed on each document were correct and in use. During the same interview they stated that the Responsive Behaviour Program had not been evaluated or updated annually. [s. 53. (3) (b)]

2. The licensee has failed to ensure that the behavioural triggers for resident #016, demonstrating responsive behaviours, had been identified.

During a family interview with Inspector #594, the SDM of resident #016, had stated that the resident had a responsive behaviour upon admission, continued with the behaviour, and had exhibited another responsive behaviour multiple times since admission. They also listed responsive behaviour triggers for resident #016.

The inspector reviewed the home's Responsive Behaviour Resident Care policy #R-45 last date reviewed May 03, 2013. The document directed staff to ensure the plan of care reflected the identification of behavioural causes and triggers.

The inspector reviewed the resident's care plan which failed to identify the behavioural triggers.

An interview was conducted with RN #103 and the Administrator/Director of Care. They both stated that the behavioural triggers for resident #016 had not been identified in the resident's plan of care. [s. 53. (4) (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 that for resident #016 and any other resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible, and to ensure the responsive behaviours program is evaluated and updated in accordance with evidence-based practices at least annually, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents’ Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a response to Residents' Council was provided in writing within 10 days of receiving Residents' Council advise related to concerns or recommendations.

Inspector #613 reviewed the home's policy titled 'Responsibilities of Different Parties/Administration' Category Resident Council, revised July 2, 2014. The document indicated that suggestions/complaints from the Residents' Council shall be documented, investigated and responded to in writing by the Administration within 10 days.

An interview was conducted with the President of the Residents' Council. They informed the inspector that the licensee did not respond in writing within 10 days of receiving concerns or recommendations from the Residents' Council.

An interview was conducted with Recreation Staff #105 and the Administrator/Director of Care. They both confirmed that a written response in writing had not been provided to Residents' Council within 10 days of receiving advice related to concerns or recommendations from Residents' Council. [s. 57. (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 that the licensee responds in writing within 10 days of receiving Residents' Council advise related to concerns or recommendations, to be implemented voluntarily.

WN #10: 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. The licensee has failed to ensure the implementation of the weight monitoring system to measure and record with respect to each resident; weight on admission and monthly thereafter and height upon admission and annually thereafter.

During a census record review of 40 randomly selected residents, Inspector #575 and #594 identified that:
a) seven residents (18%) did not have annual heights recorded,
b) 17 of 40 residents (43%) had no documented weight for one or more months. The inspector reviewed each resident census and noted that none of the residents were on a leave from the home during the time the weights were not recorded.
c) three residents did not have their admission weight taken on day of admission.

The inspector reviewed the home's Weight and Height Audit and Weight Change Protocol policy (undated) which indicated that all residents were to be weighed on admission and monthly, and that all residents were to have height measured on admission and annually there after.

An interview was conducted with RN #103 and RN #101. They stated that resident weights were completed monthly and heights were completed annually. During the same interview with RN #103 it was stated to the inspector that when a resident was admitted to the home the resident's weight and height were taken within 24 hours but sometimes the weight was not completed until the resident's first bath day. [s. 68. (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 that residents annual heights and monthly weights are completed and recorded, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks; O. Reg. 79/10, s. 71 (1).

s. 71. (6) The licensee shall ensure that a full breakfast is available to residents up to at least 8:30 a.m. and that the evening meal is not served before 5:00 p.m. O. Reg. 79/10, s. 71 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home’s menu cycle included menus for texture modified diets for both meals and snacks.

The inspector reviewed the summer and winter regular menus, and the snack menu provided by the Support Services Lead (SSL).

An interview was conducted with the SSL and Registered Dietitian. They both stated that the home has no menus specified for textured modified meals. [s. 71. (1) (b)]

2. The licensee has failed to ensure that the evening meal was not served before 1700 hours.

On August 31, 2015, Inspector #594 arrived to a dining room at 1655 hours and observed that DA #100 had completed serving the evening meal to all residents and was clearing and closing the service cart.

The inspector reviewed the MICs LTC Meal Service Times Policy (revision date August 20, 2015). According to the document, supper in the dining room was to begin at 1700 hours.

An interview was conducted with DA #100. They confirmed they completed the meal service prior to 1700hr.

An interview was conducted with the SSL. They stated that the evening meal service was to start at 1700 hours. [s. 71. (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 that the home's menu cycle included menus for texture modified diets for both meals and snacks, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff had received retraining annually relating to the following:
• The Residents' Bill of Rights
• The home's policy to promote zero tolerance of abuse and neglect of residents
• The duty to make mandatory reports under section 24
• The whistle-blowing protections

An interview was conducted with RN #101, RPN #102, RN #103 and RPN #106. They all stated that staff were required to complete self-directed learning from the duo-tangs in the nursing station and were to sign off and initial when they had reviewed the Abuse and Duty to Report policies.

The inspector reviewed the home's Zero Tolerance of Abuse and Neglect policy #LTC-630 last reviewed December 05th, 2012. According to the document the Residents' Bill of Rights and the Policy on Zero Tolerance of Abuse and Neglect would be reviewed with each new employee during orientation and annually thereafter; the staff training and education would include:
• Policy and procedures for Zero Tolerance of Abuse and Neglect
• Policy and procedures on Reporting and Whistle-blowing Protection
• Policy and procedures for Managing Complaints
• Policy and procedures for Minimizing Restraining and Use of PASDs
• Elderly Abuse Prevention Strategies and Educational Tools such as "One is One Too Many" College of Nurses of Ontario
According to the same policy, members were to sign off that they had read and understood these policies following their orientation or annual re-training and the Learning and Development Lead would maintain a record of staff completion of the Mandatory Training on the Zero Tolerance of Abuse and Neglect.

The inspector reviewed the 2014 Duty to Report training records. The inspector noted that 17/45 staff or 38% had failed to review the Duty to Report policy. The inspector reviewed the Abuse and Duty to Report policies which had not included the Resident's Bill of Rights. The inspector reviewed the 2014 training records of support staff provided to the inspector by the Learning and Development Program Leader and noted that 12/20 staff (60%) had failed to complete the Resident's Bill of Rights, Policy: Zero Tolerance for Abuse and Neglect, Mandatory Reporting Requirements, and Policy: Whistle Blower Protection retraining requirements. [s. 76. (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 all staff receive retraining annually relating to the following:
• The Residents' Bill of Rights
• The home's policy to promote zero tolerance of abuse and neglect of residents
• The duty to make mandatory reports under section 24
• The whistle-blowing protections, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee’s policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvement are required to prevent further occurrences.

The inspector reviewed the home's Zero Tolerance of Abuse and Neglect Policy #LTC-630 last date reviewed December 05, 2012, it was documented that review of the policy was to occur annually to evaluate the effectiveness of the policy.

An interview was conducted with the Administrator/Director of Care. They stated that the home had not reviewed or updated the home's Zero Tolerance of Abuse and Neglect Policy. [s. 99. (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 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, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees.

O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent

recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed immediately of an outbreak of a communicable disease as defined in the Health Protection and Promotion Act.

The inspector reviewed a report to the Director dated during 2014. According to the report a Disease Outbreak had been declared by the Porcupine Health Unit during 2014.

The inspector reviewed the home's Duty to Report policy #LTC-930 last date reviewed May 01, 2013. The documented stated that an outbreak of a reportable disease as defined in the Health Protection & Promotion Act was to be reported immediately to the Director.

An interview was conducted with RN #103 and RN #101. They stated that when an outbreak occurred staff were to contact the Infection Control Nurse. The Infection Control Nurse or the Manager on Call would contact the Director.

An interview was conducted with the Administrator/Director of Care. They confirmed the Director was not immediately informed. [s. 107. (1)]

2. The licensee has failed to ensure that the Director had been informed no later than one business day after the occurrence of resident #010 who was missing for less than three hours and who returned to the home with no injury or adverse change in condition.

Inspector #575 reviewed resident #010's health care record. It was documented during 2015, that staff observed resident #010 walking outside the home after there had been an evening event with many people in and out of the building.

Inspector #594 reviewed the home's Duty to Report policy #LTC-930 last date reviewed May 01, 2013. The document stated that when a resident who had been missing for less than three hours and who returned to the Home with no injury or adverse change in condition was to be reported within one business day to the Director.

An interview was conducted with the Administrator/Director of Care. They stated they were unsure how long the resident had eloped from the building or when the last time the resident had been seen in the building. During the same interview they stated that no report had been submitted to the Director. [s. 107. (3)]

3. The licensee has failed to inform the Director in writing within 10 days, of the analysis and follow-up action, including, i. the immediate actions that had been taken to prevent recurrence, and ii. the long-term actions planned when resident #014 was taken to hospital with an injury.

Inspector #613 reviewed a report submitted to the Director in 2014. The report identified that resident #014 was involved in an incident during 2014, and was found in their room, complaining of discomfort. The report also indicated that Resident #014 had stated their roommate, resident #013, was involved in the incident. Resident #014 was transferred to the hospital for further investigation due to a change in their health status. On the same day, the home was informed by the hospital that the resident had sustained an injury.

During 2015, the Director requested the home to amend the report in regards to the following information: the health history of resident #014 upon return to the home, history of prior incidents since 2014 and plans to prevent recurrence of the incident.

The inspector was unable to locate an amended report.

The inspector reviewed the home's incident report, assessment, the resident's progress notes and care plan upon return to the home and did not find any documented interventions to prevent recurrence of another similar incident.

An interview was conducted with the Administrator/Director of Care. They confirmed an amended report had not been submitted to the Director to identify the home's long term action plans to prevent recurrence. [s. 107. (4) 4. 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 the Director is informed immediately of an outbreak of a communicable disease as defined in the Health Protection and Promotion Act; that the Director is informed no later than one business day after the occurrence of a resident who is missing for less than three hours and who returned to the home with no injury or adverse change in condition; that when in making a report in writing to the Director: Actions taken in response to the incident, including, the outcome or current status of the individual or individuals who were involved in the incident is reported and that an analysis and follow-up action, including, i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned are reported, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.

2. Access to these areas shall be restricted to,

i. persons who may dispense, prescribe or administer drugs in the home, and

ii. the Administrator.

3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored were kept locked at all times, when not in use.

On September 08, 09 and 10th, 2015, Inspector #613 observed the door of the nursing office, where the medication carts were kept, to be ajar when no registered staff were present in the room.

An interview was conducted with RN #111. They stated that all staff were expected to close the door and ensure it was locked when leaving the nursing office.

An interview was conducted with the Administrator/Director of Care. They confirmed the expectation was that the door to the nursing office should have been closed and locked at all times when not in use. [s. 130. 1.]

2. The licensee has failed to ensure that all areas where drugs were stored was restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

Inspector #613 observed that the medication carts were stored in the nursing office when not in use. This room also contained residents' charts, and computers where staff completed their documentation.

On September 08, 09 and 10, 2015, the inspector observed personal support workers, the Recreation Therapist and the Registered Dietitian in this room.

An interview was conducted with RPN #106. They stated that all nursing staff and personal care staff had keys that provided access into the nursing office where the medication carts were stored.

An interview was conducted with RN #111. They stated that all the personal support workers and registered staff had keys and accessibility to the nursing office and indicated that the medication cart should really be in a separate room.

An interview was conducted with Administrator/Director of Care. They confirmed that staff other than those who may dispense, prescribe or administer drugs in the home, had access to the room where drugs including the medication carts, were stored. [s. 130. 2.]

3. The licensee has failed to ensure that a monthly audit was undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies and that immediate action was taken if any discrepancies are discovered.

An interview was conducted with the Administrator/Director of Care. They confirmed that monthly audits were not done on the daily count sheets of controlled substances to determine if there were any discrepancies. [s. 130. 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 steps are taken to ensure the security of the drug supply, including the following: 1. All areas where drugs are stored shall be kept locked at all times, when not in use. 2. Access to these areas shall be restricted to, i. persons who may dispense, prescribe or administer drugs in the home, and ii. the Administrator. 3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the restraint plan of care included consent by the Substitute Decision Maker (SDM) for resident #016.

Inspector #594 reviewed resident #016's health care record. The record failed to identify consent for use of a restraint that was ordered by the physician during 2015.

The inspector reviewed the home’s Minimizing Restraining of Residents policy #R-40 last date reviewed February 20, 2013. The document stated staff were to obtain and record informed consent in the resident’s chart.

An interview was conducted with the Administrator/Director of Care. They stated no documented consent to restrain resident #016 had been completed. [s. 31. (2) 5.]

WN #17: 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. The licensee has failed to ensure that all residents were offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident/SDM if payment was required.

A family interview was conducted. It was identified by a family member of resident #010, that the resident displayed signs of poor oral health.

An interview was conducted with RN #101 and RN #103. Both staff indicated that all residents were not offered annual dental assessments, only residents who exhibited poor oral health were offered a dental assessment.

An interview was conducted with the Administrator/Director of Care. They confirmed that the home had not been offering annual dental assessments to all residents. [s. 34. (1) (c)]

WN #18: The Licensee has failed to comply with LTCHA, 2007, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (2) If there is no Family Council, a family member of a resident or a person of importance to a resident may request the establishment of a Family Council for a long-term care home. 2007, c. 8, s. 59. (2).

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to assist in the establishment of a Family Council at the request of the family member of a resident or person of importance to a resident in the home.

During the entrance conference with the Administrator/Director of Care, it was stated to Inspector #594, that in 2014 a resident's family member showed interest in participating in a Family Council if other family members were interested but the Administrator/Director of Care stated that no one else was interested.

The inspector reviewed the 2014 Resident Questionnaire Summary. It documented five responses of family members of a resident or person of importance to a resident, being interested in a Family Council.

An interview was conducted with Recreation Staff #105. They stated that three family members had come forward in the two weeks prior to the inspection, showing interest in a Family Council and would attend an information meeting that was scheduled for a month in 2015. The information meeting was scheduled because some responses from the annual satisfaction survey were anonymous indicating interest in participating in a family council but Recreation Staff #105 was unable to contact those respondents.

In an interview with the Administrator/Director of Care and Recreation Staff #105 it was stated the licensee did not provide any support when resident family members identified interest in a Family Council resulting from the 2014 Resident Questionnaire. [s. 59. (2)]

2. The licensee has failed to ensure that the licensee convened semi-annual meetings to advise the resident's families and persons of importance to residents to their right to establish a Family Council.

An interview was conducted with Recreation Staff #105. They stated that no semi-annual meetings had been conducted for the past three years to advise families and persons of importance to residents of their right to establish a Family Council.

An interview was conducted with the Administrator/Director of Care. They confirmed no semi-annual meetings had been conducted. [s. 59. (7) (b)]

WN #19: The Licensee has failed to comply with LTCHA, 2007, 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

Findings/Faits saillants :

1. The licensee has failed to ensure that the package of information for residents had included, at a minimum, the long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

Inspector #594 reviewed the Resident Admission Package. It failed to identify the home's policy to promote zero tolerance of abuse and neglect of residents. The admission package documented under the important policy heading that the home had a Zero Tolerance of Abuse and Neglect policy which was available in the Main Office. [s. 78. (2) (c)]

2. The licensee has failed to ensure that the package of information for residents had included, at a minimum, an explanation of the duty under section 24 to make mandatory reports.

Inspector #594 reviewed the admission package. It failed to identify the home's policy to promote zero tolerance of abuse and neglect of residents or an explanation of the duty under section 24 to make mandatory report. The admission package documented under the important policy heading that the home had a Zero Tolerance of Abuse and Neglect policy which was available in the Main Office. [s. 78. (2) (d)]

3. The licensee has failed to ensure that the package of information for residents had included, at a minimum, the name and telephone number of the licensee.

Inspector #594 reviewed the LTCH Licensee Confirmation Checklist for the Admission Process provided to the inspector by the Administrator/Director of Care. It documented the name and telephone number of the licensee as South Centennial Manor.

The inspector reviewed the Ministry of Health and Long-Term Care documentation stating the licensee as Anson General Hospital.

The inspector reviewed the home's admission package which documented a contact information as South Centennial Manor LTC Division – Anson General Hospital with a telephone number for South Centennial Manor.

An interview was conducted with the Administrator/Director of Care They stated to the inspector that the licensee name and phone number was not included in the package. [s. 78. (2) (h)]

WN #20: 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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

During the course of the inspection, Inspector #575 and #594 identified lingering offensive odours in a hall on September 02 and on September 09, 2015 at 0945, 1425 and 1845. As well the inspectors identified lingering offensive odours in a different hall on September 02, 08, 09 and 10, 2015.

An interview was conducted with Hskg Staff #114. They described the daily cleaning routine including returning to an area where an offensive odour may linger to clean again. During the same interview they stated that in some cases nothing could be done after following the procedures to re-clean but the odour would gradually dissipate. Hskg #114 indicated to the inspector that this was the case with the odour in the first hall.

An interview was conducted with the SSL. They stated that the home does not have written procedures on lingering odours. During the same interview they stated that staff were directed to follow what they had been initially trained on when dealing with lingering odours. [s. 87. (2) (d)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance

Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home’s written policy to promote zero tolerance of abuse and neglect of residents identified the training and retraining requirements for all staff including:
i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
ii. situations that may lead to abuse and neglect and how to avoid such situations

Inspector #594 reviewed the home’s Zero Tolerance of Abuse and Neglect policy #LTC-630 last date reviewed December 5, 2012. The document failed to identify the training and retraining requirements for all staff including:
i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
ii. situations that may lead to abuse and neglect and how to avoid such situations. [s. 96. (e)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (5) The licensee shall ensure that a written record is kept of the results of the quarterly evaluation and of any changes that were implemented. O. Reg. 79/10, s. 115 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept of the results of the quarterly evaluation of the medication management system and of any changes that were implemented.

An interview was conducted with the Administrator/Director of Care. They confirmed that the home did not have a written record of the quarterly evaluation of the effectiveness of the medication management system in the home and their recommendations to improve the system. [s. 115. (5)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (5) The licensee shall ensure that a written record is kept of the results of the annual evaluation and of any changes that were implemented. O. Reg. 79/10, s. 116 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept of the results of the annual evaluation of the medication management system and of any changes that were implemented.

An interview was conducted with the Administrator/Director of Care. They confirmed that the home does not have a written record of the annual evaluation of the effectiveness of the medication management system in the home and their recommendations to improve the system. [s. 116. (5)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 141. Licensee to stay in contact

Specifically failed to comply with the following:

s. 141. (1) Every licensee of a long-term care home shall maintain contact with a resident who is on a medical absence or psychiatric absence or with the resident's health care provider in order to determine when the resident will be returning to the home. O. Reg. 79/10, s. 141 (1).

Findings/Faits saillants :

1. The licensee has failed to maintain contact with a resident who was on a medical absence or with the resident's health care provider in order to determine when the resident would be returning to the home.

During a census record review of 40 randomly selected residents, Inspector #594 identified in a progress note that resident #003 was on a medical absence during a month in 2015, and no further documentation was found until 30 days later, which documented that the resident returned.

An interview was conducted with RN #103 and RN #101. They stated that when a resident was on a medical absence, staff were to call every shift to obtain an update regarding the resident's status and document in the progress notes.

An interview was conducted with the Administrator/Director of Care. They confirmed that there was no documentation of staff having maintained contact with resident #003 who had been on a medical absence. [s. 141. (1)]

WN #25: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

During the initial tour of the home on September 02, 2015, Inspector #575 observed a resident room with a droplet/contact isolation sign posted outside of the resident's room with an isolation cart.

RN #103 indicated to the inspector that the resident was on contact precautions for MRSA.

During that same observation, a staff member walked into the resident's room, picked up a basin, walked across the hallway into the utility room, filled the basin with water, walked back into the resident's room, came back out into the hallway, applied a gown and then walked into the resident's room, applied a mask and then shut the door. No gloves were observed to be applied and no hand washing was observed before entering the resident's room or before donning the personal protective equipment (PPE). The inspector overheard the staff indicate that the resident was receiving a bed bath.

The inspector reviewed the home's policy titled 'Caring for Positive MRSA/VRE/CRE Patients/Residents' number IC - 255, last reviewed August 2011. The document indicated that hand hygiene must be performed by all team members before donning and after removing PPEs following contact with a patient/resident or contact with environmental surface in the patient/resident's room. Gloves must be worn when providing direct care to any resident who has or is suspected of having infection or colonization with MRSA ,Vancomycin-Resistant Enterococci (VRE) or Carbapenem-resistant enterobacteriaceae (CRE) and surgical procedure masks were to be worn for direct care to residents with MRSA to decrease nasal acquisition by the health care worker.

The home's policy titled 'Contact Precautions' number IC - 130 last reviewed May 2011, indicated that if a health care worker entered a contact precautions room without a gown and was then required to perform an activity that required a gown, he/she must remove gloves, clean hands, exit the room, put on a gown and clean gloves then return to the room.

An interview was conducted with RN #103. They indicated that staff were to wear a gown and gloves when providing direct care. [s. 229. (4)]

Issued on this 23 day of December 2015 (A1)

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

Original report signed by the inspector.

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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
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Bureau régional de services de Sudbury
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Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : MONIKA GRAY (594) - (A1)

Inspection No. / No de l'inspection : 2015_376594_0026 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 021564-15 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Dec 23, 2015;(A1)

Licensee / Titulaire de permis : ANSON GENERAL HOSPITAL
58 Anson Dr., IROQUOIS FALLS, ON, P0K-1E0

LTC Home / Foyer de SLD : SOUTH CENTENNIAL MANOR
240 FYFE STREET, IROQUOIS FALLS, ON, P0K-1E0

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Diane Stringer

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To ANSON GENERAL HOSPITAL, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that resident #016 is reassessed and the plan of care reviewed. The plan shall include (but not limited to):
1. The reassessment of resident #016's responsive behaviours.

2. Identification of the behavioural triggers for resident #016, how these triggers will be managed and the interventions to be taken by each staff discipline when triggers are present.

3. The licensee develop and implement a plan to ensure visitor #200 does not contribute to resident's responsive behaviours.

This plan may be submitted in writing to Long-Term Care Homes Inspector Monika Gray at 159 Cedar Street Suite 403, Sudbury, Ontario, P3E 6A5. Alternatively, the plan may be emailed to the inspector at monika.gray@ontario.ca or by fax at (705)564-3133.

This plan must be received by January 8, 2016 and fully implemented by January 22, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #016's plan of care was reviewed and revised at any time when care set out in the plan had not been effective.

During a family interview with Inspector #594, the SDM of resident #016, had stated that the resident had a responsive behaviour upon admission, continued with the behaviour, and had exhibited another responsive behaviour multiple times since admission. The resident was provided a device, but the SDM stated that many times the device would not work.

On September 02, 2015, at 1000 hours, Inspector #594 observed resident #021 trying to minimize resident #016's responsive behaviour.

On September 02, 2015, at 1800 hours, Inspector #594 and #575 observed resident #016 and a second resident exhibit responsive behaviours. Resident #016 was observed by the inspectors to exhibit responsive behaviours. During this same observation, resident #021 was trying to minimize resident #016's responsive

behaviour. The inspectors observed that after a period of time a staff member arrived to respond to resident #016's responsive behaviour.

Inspector #594 and #575 met with the ADOC and the CNO regarding the high risk concerns of resident #016's responsive behaviour. At the Inspectors' request, a plan was immediately developed by the ADOC and CNO.

During an interview with the inspector, the CNO indicated that there was a frequent visitor (Visitor #200) to the home who had contributed to the resident's responsive behaviours.

An interview was conducted with RN #103. They stated that resident #016 exhibited a responsive behaviour because visitor #200 would contribute to the resident's responsive behaviours. RN #103 stated to the inspector that staff were aware that they must respond as quickly as possible when resident #016 was exhibiting responsive behaviours but they had very limited staff in the evening (two registered staff and three direct care staff) and that it was difficult to respond quickly.

On September 10, 2015, at 1744 hours Inspector #594 observed visitor #200 contribute to a resident's responsive behaviours.

An interview was conducted with RN #101 who stated that a few weeks prior a family member of another resident contributed to resident #016 responsive behaviour. A month prior another visitor to the home contributed to resident #016's responsive behaviour. RN #101 further stated to the inspector that there is not enough staff at night because registered staff must ensure medications were locked and direct care staff must ensure the residents they were assigned to care for were safe before attending to such responsive behaviour incidents.

The inspector reviewed the resident's progress notes and found that during one year, 27 documented entries of the resident having responsive behaviours and 15 documented entries of the resident exhibiting another responsive behaviour. The inspector further noted the device was changed in 2015 when staff observed the device not functioning.

During a month in 2015, it was documented that on five occasions the device did not function.

Inspector #594 reviewed resident #016's most recent electronic care plan which stated a focus of a responsive behaviour problem and listed interventions.

Inspector #594 reviewed the home's Responsive Behaviour Resident Care policy #R-45 last date reviewed May 3, 2013, which documented that the plan of care was resident focused and the care plan must include description of the responsive behaviour/condition; level of risk and to whom; identified triggers/causes of behaviour; interventions, strategies and techniques; objectives of the interventions; medication regime and reassessment time frames.

During interviews with the inspector RN #101, RN #103, RPN #117 and PSW #118 all stated when the resident was exhibiting responsive behaviours staff would try an intervention and although this worked at times, it was very difficult to redirect the resident.

An interview was conducted with the Administrator/Director of Care. They stated resident #016's responsive behaviour trigger and that it was not identified in the plan of care.

The decision to issue this compliance order was based on the severity which indicated actual risk of resident #016's responsive behaviour because the care plan failed to provide updated interventions past a month in 2014 that had been effective. Although the scope was isolated, there is a history of non-compliance with s. 6 of the LTCHA, 2007. A Voluntary Plan of Correction was issued during Critical Incident Inspection 2013_138151_0029 and during Resident Quality Inspection 2014_282543_0025. (594)

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

Jan 22, 2016

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (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 address the steps taken to prevent resident entrapment addressing the bed systems that failed the bed assessment. The plan shall include (but not limited to):

1. Steps to address the 14 beds that failed the entrapment zones.

2. A process to ensure that all residents, who use bed rails and their bed system are assessed using an interdisciplinary team approach, which at a minimum shall include the DOC, a Physiotherapist or Occupational Therapist and a Registered Nurse.

3. A process to ensure that the residents' plans of care include the completion of a bed rail use assessment, incorporating the guidelines identified in the document titled "Clinical guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003" for the current bed rails in use.

This plan may be submitted in writing to Long-Term Care Homes Inspector Monika Gray at 159 Cedar Street Suite 403, Sudbury, Ontario, P3E 6A5. Alternatively, the plan may be emailed to the inspector at monika.gray@ontario.ca or by fax at (705)564-3133.

This plan must be received by January 15, 2016 and fully implemented by January 29, 2016.

Grounds / Motifs :

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

A) On September 02, 04, and 08, 2015, Inspector #575 observed two bed rails in the up position on resident #011's bed (the resident was not in bed).

On September 09, 2015, the inspector observed the same rails in the up position and the resident in bed.

An interview was conducted with RPN #106. They indicated that the resident used the bed rails to assist with mobility in bed.

B) On September 02, 04, and 08, 2015, Inspector #575 observed one bed rail in the up position on resident #010's bed (the resident was not in bed).

On September 10, 2015, the inspector observed two bed rails in the up position and the resident in bed.

An interview was conducted with PSW #109. They indicated that the resident used two bed rails when in bed for safety and bed mobility.

The inspector reviewed the home's 'Bed Entrapment Prevention Program' dated July 2015, which was provided by the Administrator/Director of Care. Attached to the document was a memo dated September 08, 2015, to RN's, RPN's, and PSW's regarding bed entrapment and bed rails with a bed rail risk assessment form attached. The document indicated that each resident would have a formal bed rail risk assessment on admission and be reassessed on readmission, at significant changes in condition and following any incident related to safety in bed. The document further indicated that the resident's electronic health record should have included a bed rail risk assessment.

An interview was conducted with the Administrator/Director of Care. They confirmed that registered staff were to complete the bed rail risk assessment for each resident and that the assessments were not completed as planned.

The inspector noted that during an inspection conducted in October 2014 (#2014_282543_0025), the home was issued a written notification (WN) for the same non-compliance (NC). On February 18, 2015, the home submitted a plan that indicated all beds were scheduled to be assessed during a week in 2015. (594)

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

On September 02, 2015, Inspector #575 observed two maintenance staff conducting bed entrapment assessments.

Inspector #575 reviewed completed bed entrapment assessments and noted that 14/71 beds or 20% failed some, or a combination, of zones 1,2,3 and 4.

On September 09, 2015, the inspector requested from the Administrator/Director of Care, the home's plan to address the entrapment risks associated with the beds which failed the entrapment tests. The Administrator/Director of Care indicated that after all the resident bed rail assessments were completed, the home would order new bed rails for those that could be replaced and that some beds would need to be replaced.

Inspector #575 reviewed a Compliance Plan submitted to the Ministry of Health and Long-Term Care On February 18, 2015, that indicated all beds were scheduled to be assessed during the a week in 2015.

Inspector #575 conducted an interview with the Administrator/Director of Care. They confirmed to the inspector that bed entrapment assessments were completed five months after the scheduled date in 2015.

Inspector #594 conducted an interview with the Administrator/Director of Care on September 11, 2015, and they confirmed that no bed rail assessments had been completed on any residents, therefore, no steps were taken to prevent resident entrapment.

The decision to issue this compliance order was based on the severity which indicated the potential for actual harm specifically to residents whose bed failed the bed entrapment assessment and that no resident was assessed for use of a bed rail (s). The scope was widespread and there was previous non-compliance issued with s.15 of the O.Reg 79/10 during Inspection 2014_282543_0025. (594)

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

Jan 29, 2016

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee shall ensure that training is provided for staff who provide direct care to residents and who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices; and for staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs.

Grounds / Motifs :

1. The licensee has failed to ensure that training had been provided for all staff who applied physical devices or who monitor residents restrained by physical devices including the application, use and potential dangers of these physical devices.

An interview was conducted with RN #101, RPN #102, RN #103 and RPN #106. They all stated that staff were required to complete self-directed learning from the duo-tangs in the nursing station and were to sign off and initial when they had reviewed the Restraint policy.

The inspector reviewed the 2014 restraint training records. The inspector noted that only 30/44 of required staff (68%) had completed review of the Restraint policy.

The inspector reviewed the home's Minimizing Restraining of Residents policy #R-40 last date reviewed February 20, 2013. According to the document, direct care team members must receive annual retraining on restraint policies and procedures and the correct use of equipment as it related to their job.

An interview was conducted with the Administrator/Director of Care. They stated that staff were initially trained in the application, use and potential dangers but had not completed annual training on the application of restraints and should have.

The decision to issue this compliance order was based on the severity which indicated potential for actual harm if not trained in the application, use and potential dangers. The scope was widespread, and there is a previous non-compliance with s. 221 of the O. Reg.79/10. During Resident Quality Inspection 2014_282543_0025 a Voluntary Plan of Correction was issued. (594)

2. The licensee has failed to ensure that training had been provided for all staff who applied Personal Assistance Service Devices (PASDs) or who monitor residents with PASDs including the application, use and potential dangers of these PASDs.

A) On September 10, 2015, the Inspector #575 observed resident #010 using a PASD.

The inspector reviewed of the resident's health care record, which revealed that staff failed to try alternatives or obtain consent to the use of a PASD for resident #010.

B) Inspector #594 observed resident #008 to have a PASD in use on September 09, 2015.

The inspector reviewed the resident's health care record, which revealed that staff failed to obtain consent for a PASD for resident #008.

An interview was conducted with RN #101, RPN #102, RN #103 and RPN #106. They all stated there was no training related to resident use of PASDs, and that staff were required to complete self-directed learning from the duo-tangs in the nursing station and were to sign off and initial when they had reviewed the policy.

The inspector reviewed the 2014 PASD training records. The inspector noted that only 30/44 required staff (68%) had completed review of the PASD policy.

An interview was conducted with the Administrator/Director of Care. They stated that staff were initially trained in the application, use and potential dangers but had not completed annual training on the application of PASDs and should have.

The decision to issue this compliance order was based on the severity which indicated potential for actual harm if not trained in the application, use and potential dangers. The scope was widespread, and there is a previous non-compliance with s. 221 of the O. Reg.79/10. During Resident Quality Inspection 2014_282543_0025 a Voluntary Plan of Correction was issued. (594)

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

Jan 29, 2016

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Order / Ordre :

The licensee shall ensure that all staff who provide direct care to residents receive annual training in responsive behaviours.

Grounds / Motifs :

1. The licensee has failed to ensure all direct care staff received the required annual responsive behaviour training.

During a family interview with Inspector #594, the SDM of resident #016, had stated that the resident had a responsive behaviour upon admission, continued with the behaviour, and had exhibited another responsive behaviour multiple times since admission.

The inspector reviewed the resident's health care record. The care plan failed to identify the behavioural triggers for the resident's responsive behaviour.

An interview was conducted with RN #101, RPN #102, RN #103 and RPN #106. They all stated that staff were required to complete self-directed learning from the duo-tangs in the nursing station and were to sign off and initial when they had reviewed the policy.

The inspector reviewed the 2014 Responsive Behaviour training records. The inspector noted that only 30/44 required staff (68%) had completed review of the Responsive Behaviours policy.

The inspector reviewed the home's Responsive Behaviour Resident Care policy #R-45 last date reviewed May 03, 2013. The document indicated that all staff, contractors providing direct care and volunteers must be orientated prior to assuming their job responsibilities and retrained annually in caring for persons with responsive behaviours and behaviour management.

The decision to issue this compliance order was based on the severity which indicated potential for actual harm if not trained in behaviour management. The scope was widespread, and there is a previous non-compliance with s. 221 of the O. Reg.79/10. During Resident Quality Inspection 2014_282543_0025 a Voluntary Plan of Correction was issued. (594)

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

Jan 29, 2016

Order # / Ordre no : 005

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

Linked to Existing Order / Lien vers ordre existant: 2014_282543_0025, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, 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;
(b) there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents; and
(c) there is an organized program of maintenance services for the home.
2007, c. 8, s. 15 (1).

Order / Ordre :

The licensee shall complete the following:
1. Ensure that there is an organized program of maintenance services for the home and is being implemented.

2. Address cosmetic fixes in resident rooms, including but not limited to, applying caulking around bathroom vanities, drywall repairs including painting

Grounds / Motifs :

1. The licensee has failed to ensure that there was an organized program of maintenance services for the home.

Inspector #594 and #575 observed all areas of the home that were identified in the compliance order issued December 18, 2014, during Resident Quality Inspection 2014_282543_0025 and observed that many areas, and additional areas remained in a state of disrepair.

The following areas were observed in a state of disrepair by the Inspectors during the inspection:
Unit A
Utility room - baseboard flooring lifted away at corner's and along wall
Tub room: floor tile missing from left of tub, floor is lifted in some of the areas
Room 2: Wear and tear in carpet in front of window, cracked sealant around bathroom vanity
Room 4: Bathroom vanity pulled away from wall at front left corner, sealant missing around the vanity, holes at carpet door entrance
Room 5: Back of bathroom vanity top surface layer missing exposed chip board
Room 6: Front of bathroom vanity chipboard exposed and band aids applied on corners of bathroom cupboard doors
Room 8: Bathroom vanity chipboard exposed, sealant missing around vanity
Room 9: Bathroom vanity corner peeling exposed chipboard, bathroom cupboard door hinges loose (resulting in cupboard doors tilted), bathroom light covering missing
Room 10: Bathroom shared with Room 9, holes in carpet near bathroom entrance
Room 11: Sealant gone around bathroom vanity, vanity starting to pull away from wall, carpet wear at foot of bed and in front of closet

Unit B
Tub room: water damage to the flooring, stained under the tub
Room 5: Paint missing from behind toilet, white paint on blue floor under radiator, top bathroom cupboard door tilted from hinge, bathroom door had gouge on door leading into bathroom, bathroom door frame at bottom of trim scuffed up and missing paint
Room 11- hole in flooring, shared bathroom vanity drawers in disrepair exposed chip board, no cover on thermostat
Room 13- bathroom vanity drawers chipboard exposed
Room 15- drywall repair not painted in room; no fixture to cover light in shared bathroom

Room 18- paint scraped off along wall

Unit C
Tub room: linoleum had bubbled
Room 2: Scrapes along dresser bottom and front, sealant missing along front of bathroom vanity, third bathroom cupboard door hinges loose (resulted in cupboard doors tilted), radiator in bathroom scratched and missing paint, wall in room beside door black scuff marks
Room 4: Drywall screws and holes in wall beside door, sealant missing from front of bathroom vanity
Room 5: Front of resident room door missing veneer at bottom and up alongside
Room 6: Wall scratched up under bulletin board, radiator missing paint in bathroom, wall paint missing from bathroom
Room 8: Bathroom vanity top worn with stains, and drywall/paint pulled away from wall corner, some drywall damage to right of window
Room 11: Hole in vinyl floor at foot of bed, sealant missing from bathroom vanity, bottom bathroom cupboard door tilted from hinge
Room 14: Large black water marks on ceiling above bed, some paint missing from wall opposite bed, missing veneer from front of bathroom vanity

Visitor washroom at front of home:
Large amount of calcium build up around water spout in sink resulting in green discolouration

The inspectors' list of observations as listed above in no way represented a comprehensive audit of all home areas.

On September 10, 2015, Inspector #594 and Maintenance Staff #120 toured the home. Maintenance Staff #120 confirmed the inspectors observations.

Inspector #594 reviewed the homes Maintenance Requisition Book. Over an eight month period, the inspector identified entries that documented various home areas in disrepair, such as holes in walls and floors, walls that needed paint, closet door not able to be closed. According to these same entries, maintenance responses indicated that some repairs required direction to be provided by the Director of Support Services, some entries did not have maintenance responses and one response indicated that a quote was received to repair the floor but was waiting for funding.

On September 10, 2015, an interview was conducted with Maintenance Staff #120. They stated that staff document in a requisition book, maintenance concerns including identified home areas that require repair. Maintenance staff would check the requisition book daily and complete a written maintenance response. They also indicated an electronic maintenance program was available but not used. During the same interview, Maintenance Staff #120 stated that areas such as where the sealant/caulking was cracked or missing around bathroom vanities, painting, cupboard doors not hung properly and addressing the floor in the tub rooms could be completed without waiting for funding.

On September 11, 2015, an interview was conducted with the Administrator/Director of Care. They stated that they, the Chief Executive Officer (CEO) and Director of Support Services were aware of the identified rooms and problems, and that the home had a preventative maintenance computer program but had not seen it in use. During the same interview they stated that areas such as missing caulking/sealant and cupboard doors that were misaligned could have been fixed.

On September 15, 2015, an interview was conducted with the Director of Support Services. They stated that staff documented in a requisition book maintenance concerns including identified home areas that required repair. The home did have an electronic maintenance program that should have been used but was not being used. During the same conversation, they stated that some maintenance repair areas such as missing caulking/sealant around bathroom vanities could have been repaired and confirmed that maintenance items addressed from Inspection 2014_282543_0025 had not been repaired.

The decision to issue this compliance order was based on the severity which indicates potential for actual harm given holes in flooring and bathroom vanities in a state of disrepair. The scope was widespread, and the licensee has a history of non-compliance with s. 15 of the LTCHA, 2007. Since 2013 the section has been issued three previous times: a compliance order on May 28, 2013, during Critical Incident Inspection 2013_138151_0017; a second compliance order on October 24, 2013, during Follow Up Inspection 2013_138151_0028, a third compliance order on December 18, 2014, during Resident Quality Inspection 2014_282543_0025 with a compliance date of March 01, 2015. (594)

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

Jan 29, 2016

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 23 day of December 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MONIKA GRAY - (A1)

Service Area Office /
Bureau régional de services : Sudbury