Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 8, 2017	2017_683126_0017	011734-17	Resident Quality Inspection

Licensee/Titulaire de permis

RELIGIOUS HOSPITALERS OF ST. JOSEPH OF CORNWALL, ONTARIO
14 York St CORNWALL ON K6J 5T2

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

ST JOSEPH'S CONTINUING CARE CENTRE
14 YORK STREET CORNWALL ON K6J 5T2

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

LINDA HARKINS (126), MELANIE SARRAZIN (592)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 23, 24, 25, 26, 27,30, 31, November 1, 2, 3, 2017

During this inspection, the following logs were inspected:
Log # 029057-17 and Log # 034983-16

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care, the Director of support Services, the Health, Safety & Education Coordinator, the Program Support Coordinator, the Nursing Care Coordinator, the Resident Care Aid, the Resident and Patients Relations Advisor, the Nurse Practitioner, two members of the Family Council, the President of the Resident Council, several Registered Nurses, Registered Practical Nurses, several Resident Care Aid (RCA), several residents and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **6 VPC(s)**
- **0 CO(s)**
- **0 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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #017 collaborate with each other
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

This inspection is a follow-up to a Critical Incident involving resident #017 who had a fall on a specified date in 2016, resulting in an injury to a specific body part.

Resident #017 was admitted to the home with several medical conditions including dementia.

A review of the written plan of care for resident #017 dated on a specified date in 2016, revealed under Activity of Daily Living that the resident was requiring two staff assist with care and for all transfers using a mechanical lift. The written plan of care further indicated that resident #017 was identified as being at high risk for falls and interventions when resident #017 was in bed were as follows:

-four bedrails up in bed for safety purposes with a specific mattress in place
-to use one specific type of bed alarm

A review of the resident's progress notes was done by the Inspector #592 which indicated that previous to the fall incident, resident #017 had several episodes where he/she was attempting to climb out of the bed.

The notes indicated that 24 days prior to the incident, the specific bed used by resident #017 was malfunctioning, not raising or lowering properly. The notes indicated that

another type of mattress with a bed alarm and another type of bed was suggested until the resident's bed would get repaired. The notes further indicated that the family member of resident #017 preferred the resident to stay on a regular mattress while the other bed was being repaired with no bed alarm.

The notes indicated that eight days later, staff had reported on rounds that resident #017 was attempting to climb out of bed through the gap in the rails, therefore a work order was sent to Occupational Therapist (OT) to assess for bed alarm and to monitor.

Approximately 90 minutes later, the notes indicates that an OT follow-up was done and that resident's #017 bed was still currently unavailable, therefore the recommendations were to monitor resident #017 closely. The notes further indicated that the family of resident #017 had express to not change the bed mattress while the other bed was under repair and were made aware that the bed alarm was removed as it was not functioning properly on the type of mattress used to replace the other bed. The notes further indicated that if resident #017 was continuing to unsafely sit up at the edge of bed or was attempting to get out of bed, that a follow-up would be done with the family members to discuss options which were: to switch the resident to another therapeutic surface which will allow a bed pad alarm, or providing the resident with the previous bed once available.

Three days later, the notes indicated that staff has reported on rounds that resident #017 was attempting to climb out of bed through the gap in the bed rails. The notes further indicated that the resident had both feet on the floor and stated that he/she was going to the washroom. The notes further indicated that the staff redirected the resident back to bed and would continue to monitor.

Approximately two hours later, the notes indicated that resident #017 was observed between the bedrails with his/her feet on the floor during the morning rounds by staff members and that the resident was settled back to bed, however the staff would continue to monitor.

On the next day, the notes indicated that the OT had received a recent report about resident #017 getting out of his/her bed. The notes indicated that the resident #017's bed was still not available, however a work order was put in, for maintenance to switch the bed with a bed alarm for safety.

Two days later, the notes indicated that the resident #017's bed was switched to another type of bed with a bed alarm due to recent reports of resident #017 trying to exit the bed.

The notes further indicated that the other bed was still not available, therefore to use alarm at all times in bed and to continue with four bed rails for safety while using a specific therapeutic mattress.

Seven days later, the progress notes indicated that resident #017 was found sitting up on the edge of the bed with his/her feet touching the floor. It is further indicated that the staff repositioned the resident and reminded the resident to ring call bell for assistance.

On the next day, the notes indicated that due to resident #017 efforts to climb out of bed through the gap between the two bedrails, work order was put in maintenance to switch with co-resident’s bed with a full bed rails for safety. The notes further indicated that the OT would do a follow-up after the bed switch was completed.

On the next day, the notes indicated that the staff had responded to the bed alarm alarming four bedrails up and that resident #017 was "seen on the floor as he/she had climbed out of bed and landed on the floor. The notes indicated that the resident was send to the hospital after the Registered staff assessment due to an injury to a specific body part .

A review of the resident's plan of care in place at the time of the incident was reviewed by Inspector #592. The plan of care was not updated to reflect the current equipment used by the resident as it was indicating that two type of beds and two type of bed alarms were used at the same time.

On October 31, 2017, in an interview with the RN in charge #108, she indicated to Inspector #592 that when a resident is identified at high risk for falls and that the interventions in place are no longer effective, the registered staff would request an assessment from the OT who would decide what other type of interventions were needed. The OT would provide verbal instructions/recommendation to the nurse in charge of the unit and then would update the resident’s plan of care. RN # 108 further indicated that immediately after receiving recommendations from the OT, interventions would be put in place within the same day. She further indicated that when the recommendation is to modify/change rails, a work order would be completed via the home’s software which will go directly to the maintenance staff department.

On November 01, 2017, in an interview with OT #122, she indicated that when a request is received to re-assess a resident, a complete assessment of the resident is completed and interventions/recommendations will be discuss verbally with the nurse in charge of

the unit, and changes will be done by the OT in the resident's plan of care. She further indicated that if a restraint or a Personal Assistive Safety Device (PASD) is recommended, the OT was the person responsible to obtain the consent from the family members. The OT further indicated that when they recommend that the four bed rails should be replaced by two full rails that it is the same risk and same restraint in place, therefore there was no need to re-obtain the family consent and go over the restraint process as it was already in place. She further indicated that for resident #017, the order for the four bed rails was in place since several months, therefore there was no need to go through the whole process again, therefore a work order was sent directly to the maintenance staff on that specific day prior to the incident. She further indicated that the change of equipment/side rails should be proceeded by the maintenance but was unsure how the process worked for that department when the recommendations were done after hours.

On November 01, 2017, in an interview with maintenance staff #121 who worked on the day of the incident, he told Inspector #592 that when he is working after regular hours, he is accountable to complete all the work orders received from the previous day and the current day by prioritizing the resident care and safety. He further indicated that if work orders are not completed, he has to stay and complete them. The maintenance staff member did not recall the specific work order submitted on the day prior to the incident but indicated to Inspector #592 that the maintenance were not allowed to change or modified any type of rails unless it was authorized by the registered staff only. He further indicated that when he receives a work order for rails, it was considered a priority, therefore he usually consults with the RN on the floor to ensure that authorization was received from the family members and then the changes to the bed are done immediately. He further indicated that he does not recall which nurse he spoke to on that particular day but told the Inspector that usually these were the steps taken.

On November 01, 2017, in an interview with RPN #119 who was working on the unit on the day of the incident, she indicated to Inspector #592 that at the time of the incident, resident #017 had a bed alarm with four bed rails in place but the resident was still trying to climb out of bed in between the two rails. She further indicated that she does not recall any specific interventions or directives being requested on that day.

On November 01, 2017, in an interview with the Program Support Coordinator (PSC) in charge of OT staff members, she indicated to Inspector #592 that she does the follow-up of the tickets created once a work order has been done by the OT. She further indicated that once the resident was seen by OT, verbal outcomes would be communicated with

recommendations to the nurse on the floor and the residents plan of care would be updated by the OT staff member. She further indicated that if a switch of bed is required, maintenance has to keep track due to rails and bed assessments and record every changes in a binder. She further indicated that if work orders are not completed upon receiving a request at the end of a shift, it is in the expectation that the work order would be completed on the next shift or the next day depending on priorities and issues, however should be done within 24 hours.
When Inspector inquired about resident #017, she showed to the Inspector the work order form which indicated that the work order was done on the previous day of the incident by the OT and confirm that the switch of equipment for resident #017 did not occurred. The PSC further indicated that four bed rails and two full bed rails were two different types of restraints, therefore the whole process should have been re-started with new consent and new physician orders with an update and reassessment of the resident. She further indicated that the plan of care was not clear as per which type of bed, mattress and bed alarm were in used at the time of the incident. Furthermore, she indicated that when a work order is send to the maintenance department, especially from another professional such as OT it is in the expectation that the work must be proceeded. The PSC further indicated that the home will review their communication system in order for the different department involved in the different aspects of care for residents, to collaborate with each other in the implementation of the plan of care for the residents. [s. 6. (4) (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 staff and others involved in the different aspects of care of resident #017 collaborate with each other
in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to immediately report to the Director an allegation of abuse of a resident by staff member.

On a specified date in 2017, resident #019's family member informed the evening Registered Practical Nurse (RPN) #114, that the resident had told him/her that the Personal Support Worker (PSW) that got him/her ready in the morning was very rough when providing care.

On October 30, 2017, during an interview, the Executive Director (ED) indicated to Inspector #126 that resident #019's Substitute Decision Maker (SDM) had contacted her six days after the incident to express concerns about the incident of that specified date in 2017. The ED indicated that the investigation was initiated and that prior to that date she was not notified of any incident.

On October 31, 2017, the Director of Care (DOC) indicated to Inspector #126 that she was made aware of the allegation of abuse by the ED on the day the ED was notified by the SDM.

On November 1, 2017, telephone discussion held with RPN #114, indicated to Inspector #126 that she had not notified anyone of the incident of that specified date in 2017 and wasn't sure of the process.

The incident of allegation of abuse staff to resident was not immediately reported to the Director by RPN #114 on the specified date of 2017 and neither by the ED or the DOC when they were notified by the SDM. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care must be based on, at a minimum, interdisciplinary assessment with respect to the resident health conditions, including pain.

On October 25, 2017, resident #018 was identified via the Resident Quality Inspection (RQI), to have Increased moderate to severe pain.

Resident #018 was admitted to the home with several diagnosis which include a progressive disease.

On October 26, 2017, resident #018's progress notes were reviewed for the period of four months and several progress notes indicated that resident #018 complained of generalized discomfort and was given an analgesic with relief.

On October 26, 2017, Inspector #126 reviewed resident #018's list of medications. It was noted that resident #018 was not on a regular dose of analgesic and the analgesic was administered when needed as per the Physician standing Orders.

On October 30, 2017, Registered Practical Nurse (RPN) #114 indicated to Inspector #126, that resident #018 was not receiving a regular dose of analgesic. Inspector #126 and RPN #114 reviewed resident #018 plan of care and have not found any documentation related to pain management.

On October 30, 2017, Nurse Practitioner (NP) indicated to Inspector #126, that resident #018 does have pain. The NP indicated that they have to organize a Care Conference with the Substitute Decision Maker (SDM) to discuss pain management.

As part of this RQI, resident #010 and #019 as above were also identified for Increased moderate to severe pain. Both health care records were reviewed and it was noted that they did not have a written plan of care related to pain management.

Resident #010, #018 and #019 do not have a written plan of care related to pain management. [s. 26. (3) 10.]

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 plan of care must be based on, at a minimum, interdisciplinary assessment with respect to the resident health conditions, including pain, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area that is secure and locked.

On October 27, 2017, Inspector #126 observed a transparent plastic container on the filing cabinet on the "Mantle unit" nursing station, containing several medicated creams and ointments. Several transparent plastic bags were observed on the filing cabinet of "Kane unit" nursing station, containing medicated cream and ointments.

On October 31, 2017, Inspector #126 observed several transparent plastic bags on the filing cabinet of the "Kane unit"nursing station, containing the above described medicated cream and ointments.

Medicated creams and ointments were not kept in an area that was secure and locked. [s. 129. (1) (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 medicated cream and ointment are stored in an area that is secure and locked, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is administered to a resident in the home unless the drug has been prescribed for the resident.

On November 1, 2017, Inspector #126 reviewed the home internal Medication Incident Report and noted the following:

The Medication Incident Report (MIR) form dated a specified date in 2017, indicated that Registered Practical Nurse (RPN) #114, "accidently" gave 1 tab of an antiemetic instead of 1 tab of a laxative to resident #026 and resident #027. No serious adverse effect was observed for both residents.

The MIR form dated a specified date in 2017, indicated that resident #028 was to receive an analgesic for 10 days but the transcription order was documented that the medication was to be given for 5 days instead of the prescribed 10 days. No adverse reaction was documented.

The MIR form dated a specified date in 2017, indicated that resident #029 has received the wrong insulin. No adverse reaction was documented.

Resident #026, #027, #028 and #029 did not received their medications as prescribed. [s. 131. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no drug is administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident is reported to the resident or the resident's Substitute Decision Maker (SDM).

On November 1, 2017, Inspector #126 reviewed the home internal Medication Incident Report and noted the following:

Inspector #126 reviewed 5 Medication Incident Reporting Forms (MIRF) and it was noted that none of these incidents were reported to the respective resident's SDM.

On November 2, 2017, the Director of Care (DOC) indicated to Inspector #126 that the home is in the process launching a new Point Click Care Incident Report Program that will improve the reporting and the monitoring of requirements when an incident occurs. [s. 135. (1)]

2. The licensee has failed to ensure that (a) all medications incidents and adverse drug reaction are documented, reviewed and analyzed, (b) corrective action is taken as necessary and a written record is kept of everything required under clauses (a) and (b).

On November 1, 2017, Inspector #126 reviewed the home's internal Medication Incident Report process and noted the following:

Inspector #126 reviewed 5 Medication Incident Reporting Forms (MIRF) and 3/5 did not have the following sections completed: Clinical significance, comments and plan of action, discussion with the nurse responsible, repeat incident, education needed and signature of the Director of Care.

On November 2, 2017, the Director of Care indicated to Inspector #126 that she does review the MIRF but did not document the review, analysis and action taken be the home, on all the form. [s. 135. (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 every medication incident involving a resident is reported to the resident or the resident's Substitute Decision Maker (SDM) and hat (a) all medications incidents and adverse drug reaction are documented, reviewed and analyzed, (b) corrective action is taken as necessary and a written record is kept of everything required under clauses (a) and (b), to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee has failed to ensure that the licensee respond in writing within 10 days of receiving the Family Council advice related to concerns or recommendations.

On October 30, 2017, discussion held with the President of the Family Council and one Family Council Member at their request. Both indicated to Inspector #126 that the licensee does not respond within 10 days to the Family Council advice.

On October 30, 2017, discussion held with Executive Director (ED) regarding the legislative requirement to responding within 10 days. The ED indicated that she was not aware of this legislative requirement and had not responded within 10 days. [s. 60. (2)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to consult regularly with the Resident Council, and in any case at least every three months.

The home's Resident Council has approximately eight to twelve resident meetings per year and these are held on a monthly basis.

During a review of the Resident Council minutes, Inspector #592 noted that the licensee had not consulted with the Resident Council since February 2017.

During an interview on October 27, 2017 with the Resident and Patient Relation Adviser, who is the staff member appointed by the Resident Council to assist the residents, indicated that the Administrator who represents the licensee was participating in the Resident's Council meetings once year to share the results of the satisfaction surveys.

During an interview with the Administrator, she indicated that she was the representative of the licensee. She indicated that she was not attending to the Resident Council meetings every 3 months. She further indicated that the last consultation with the Council was done in February 2017 as she was not aware of the requirements. Furthermore she indicated that she has not approved and revised the Resident Council minutes since February, 2017.

The Administrator further indicated that she will meet with the President of the Resident Council today in order to be invited at the next Resident Council meeting. [s. 67.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to document and make available to the Family Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

On October 30, 2017, discussion held with the President of the Family Council (FC) and one Family Council Member at their request. Both indicated to Inspector #126 that the licensee has not made available to the FC the results of the satisfaction survey in order to seek advice of the Council about the survey.

On November 2, 2017, discussion held with the Program Support Coordinator indicated to Inspector #126 that the result of the satisfaction survey was not shared with the FC. [s. 85. (4) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #017's written record is kept up to date at all times.

On October 24, 2017, Inspector #126 interviewed Registered Practical Nurse (RPN) #114 regarding resident #017. In reviewing resident #017's health care record, it was noted that a Medical Certificate of Death- Form16 was filled out by Physician #123 which included the information of the deceased, the cause of death and the certification. The only information missing was to add the month, day and year. Inspector #126 asked RPN #114 if resident #017 had passed and answered that resident #017 was alive. RPN #114 could not explained why a Medical Certificate of Death (MCOD) was on file.

On October 24, 2017, interview held with Registered Nurse (RN) #108, indicated to Inspector #126 that it was not a common practice and was not aware that a MCOD was filled out for resident #017. The next day, RN #108 indicated that she had a discussion with Physician #123 and was informed that at a specific time resident #017 appeared to be dying and the (MCOD) was filled out at that time and could be used during that night should the resident decease.

On October 24, 2017, interview with the Executive Director and the Director of Care, who indicated to Inspector #126 that MCOD should only be filled at the time of the resident death.

Resident #017 written record was not kept up to date by having a MCOD on file when he/she was still alive. [s. 231. (b)]

Issued on this 28th day of November, 2017

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

Original report signed by the inspector.