Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

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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 |
|---|---|---|---|
| May 9, 2014 | 2014_198117_0011 | O-000302-14 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

ST. PATRICK'S HOME OF OTTAWA INC.
2865 Riverside Dr., OTTAWA, ON, K1V-8N5

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

ST PATRICK'S HOME
2865 RIVERSIDE DRIVE, OTTAWA, ON, K1V-8N5

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

LYNE DUCHESNE (117), ANANDRAJ NATARAJAN (573), PAULA MACDONALD (138), WENDY PATTERSON (556)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): April 14, 15, 16, 17, 22, 23, 24, 25, 28 and 29, 2014**

**Four other complaint inspections, Logs #O-001063-13, #O-001163-13, #O-001183-13 and #O-000215-14 , were conducted concurrently with the Resident Quality Inspection and findings are integrated into this report.**

**During the course of the inspection, the inspector(s) spoke with Chief Executive Officer, Vice President Resident Care, Vice President Clinical Care, Vice President Building Operations, Coordinator Resident & Family Services,**

Registered Dietitian, Manager of Human Resource, Manager of Support Services, Food Services Supervisor, Coordinator of Clinical Practice and Performance, RAI MDS Coordinator, several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), several Nutritional Services Aides, several Housekeeping Aides, Physiotherapy Aides, Physiotherapist, Occupational Therapist, Laundry Aides, Ward Clerk, Manager of Recreation and Volunteers,Recreologists, Executive Director of Ottawa Home Health, Ottawa Home Health nursing staff, several residents, several family members, representatives of the Resident Council and Co-chair of the Family Council.

During the course of the inspection, the inspector(s) reviewed several residents health care records, observed provision of resident care and services, observed resident-staff interactions, observed several breakfast and lunch time meal services, observed beverage and snack passes, examined resident rooms and common areas, examined resident care equipment including mobility and transfer aids, reviewed the registered nursing staffing schedule, reviewed the following home policies: Resident Abuse-Prevention, Reporting and Elimination of, PM0501-03, July 1 2010; Medication Reconciliation IX NSG-32.00, October 2013; Narcotics Administration and Control of IX NSG-25.00, October 2013; Self-Medication Program IX NSG G-26.00, October 2013; Falls Preventions Management Program Part II-R49, Restraint Minimizing Program, June 2012; Restraint Initiation/Monitoring/Documentation IX SG E-15.00(b), October 2013; Use of Personal Assistive Devices - PASD IX NSG E-15.00(a); Skin and Wound Program, June 2012; Infection Control Program; reviewed staff and agency training related to Prevention of Abuse Policy; Handbook for Residents and Families; as well as the 2013-2014 Resident Council Meeting Minutes and the 2013-2014 Family Council Meeting Minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 8. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,**
**(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).**
**(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).**

**Findings/Faits saillants :**

The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, section 8 (1) (b) in that the licensee failed to ensure that there is an organized program of personal

support services for the home to meet the needs of the residents on Waterford House and Wexford House.

LTCH Inspector #138 was on Waterford House, a 32 bed unit on the fifth floor, the mornings of April 22 and 23, 2014 and on Wexford House, another 32 bed unit on the fifth floor, on April 24 and 25, 2014. The LTCH Inspector established that the breakfast meal service on both units is scheduled to begin at 8:00am and is scheduled to finish at 9:30am when the nutritional service aide for each unit is required to remove the bulk of the hot breakfast menu items from the dining room and return to the main kitchen. It was also established that the RPNs for both units will provide assistance to residents in the dining room when able but that the RPNs are also assigned to the residents' medication pass and can only provide intermittent assistance to residents with their meals.

It was further established on Waterford House that the unit recreologist is planned to assist residents in the dining room from 8:00am until 8:45am after which a PSW is to join the dining room and continue to provide assistance to residents. It was noted by LTCH Inspector #138 on April 22 and 23, 2014 on Waterford House that the recrealogist and her student were available in the dining room assisting residents, however, it was noted that a PSW did not come to the dining room at 8:45am both mornings as was planned. Once the recreaologist and her student left the dining room the RPN was the only staff member present to assist the residents with their meals (the nutritional service worker was present until 9:30am but was busy with food production and service duties). It was noted that the RPN was not solely dedicated to the dining room at this time as she had medication administration duties to complete. It was also noted by the LTCH Inspector on both days on Waterford House that several residents were brought to the dining room after the planned finish time for the breakfast meal (9:30am) and, as a result, hot food menu items such as eggs, hot cereal, and fortified cereal were not available to those residents as these items had been taken away. It was also observed by the LTCH Inspector that the PSWs were not present in the Waterford dining room until approximately 9:45am both mornings. This is fifteen minutes after the scheduled completion of the meal service. It was also noted by the LTCH Inspector that the PSWs in the dining room at 9:45am were busy assembling breakfast meals and making toast since the nutritional service aide was gone. This meal assembling task competed with the PSWs ability to assist the residents with their meals.

On Wexford House, on April 23 and April 24, 2014 the LTCH Inspector observed that

the PSW's were not in the dining room until approximately 9:45am both days. This, again, is fifteen minutes after the breakfast meal is scheduled to be completed and after the bulk of the hot foods menu items are removed from the unit. Once the PSWs arrived in the dining room at 9:45am, meal assembly became their primary duty as the nutritional service aide was no longer on the unit. The duty of assembling meals and making toast competed with the PSWs time to provide assistance to residents in the dining room. It was noted by the LTCH Inspector that several residents were brought to the dining room after the scheduled completion of the breakfast meal service (9:30am). The last resident was brought into the dining room at 10:15 am.

It should be noted that lunch on both Waterford House and Wexford House is at 12:00 pm and for many residents this is approximately two hours after the breakfast meal. The home has not provided adequate time between the breakfast and the lunch meal to ensure a healthy appetite to promote increased intake at the lunch meal for these residents.

The following resident specific observations were made by LTCH Inspector #138 at breakfast the mornings of April 22 and 23, 2014 on Waterford House:

Resident #5
April 22, 2014 - Resident #5 was brought into the dining room at 9:26 am and provided hot cereal several minutes later. The resident was then almost immediately provided the next course of breakfast of eggs and toast before having adequate time to finish his/her hot cereal. O.Reg 79/10 section 73 (1) 8 states that residents shall be offered course by course service of meals. The eggs and toast were provided to the resident as the hot food was being taken away from the dining room.
April 23, 2014 – Resident #5 finished the cereal portion of the meal at 9:38am and was not provided the next course until almost twenty minutes later. The resident was not offered a choice and instead was provided a muffin and one boiled egg. The plan of care for the resident stated that the resident is to be provided a double egg portions at breakfast. No additional egg was offered to the resident. In addition, there was no indication in the plan of care that the resident is a late riser in the morning.

Resident #19
April 22, 2014 – Resident #19 was brought into the dining room at 9:35am, after the scheduled end of the meal service, by staff and was provided only toast and orange juice. The resident was not offered any choice from the menu including eggs as they were no longer available.

April 23, 2014 – Resident #19 was brought into to the dining room at 9:36am by staff. Staff were overheard discussing the resident's preference for breakfast and the RPN stated that it was oatmeal. No oatmeal was available as it had been removed at 9:30am so staff provided the resident with cold cereal instead. Toast was later provided to the resident but there were no eggs available to be offered to the resident. The resident's plan of care was reviewed and there was no indication that the resident has a preference to be a late riser.

Resident #16
April 22, 2014 – Resident #16 came to the dining room at 9:40am and was provided cold cereal and toast. The resident was not offered a choice of hot cereal or eggs as neither were available any longer. The resident voiced frustration to the LTCH Inspector stating that he/she wishes to be up earlier in the morning as he/she suffers leg cramps if in bed too long. The resident further stated that he/she is dependent on staff to get him/her up and has to wait until staff are ready to assist him/her which can be late in the morning. The LTCH Inspector reviewed the resident's plan of care and there was no indication that the resident was to be a late riser. The LTCH Inspector reviewed the progress notes on the resident's health care record and viewed entries that outlined complaints from the resident regarding leg pain early in the morning.

Resident #20
April 23, 2014 – Resident #20 was brought into the dining room by staff at 9:41am. The resident was not offered eggs or hot cereal as both were no longer available. The resident's plan of care did not outline that the resident is a late riser.
April 24, 2014 – Resident #20 was already in the dining room at 9:20am when the LTCH Inspector arrived. The resident was exhibiting difficulty eating scrambled eggs and was observed to struggle to attempt to fed self the eggs for the next fifteen minutes when the resident was observed to drop his/her spoon and eat the eggs with his/her fingers. The resident continued to attempt to fed self with his/her fingers for another fifteen minutes when the resident was cleaned up by staff. No feeding assistance had been provided by staff. The resident's plan of care stated that the resident required set up and supervision while eating.

Resident #24
April 22, 2014 – Resident #24 was brought into the dining room by staff at 9:45am and provided cold cereal and toast. The resident was not offered a choice of foods as hot cereal and eggs were no longer available. It was observed by the LTCH Inspector on both April 22 and April 23, 2014 that there was a small container on the counter in the

dining room labelled protein powder for the resident with instructions to put in the resident's hot cereal. The protein powder was not provided to the resident both days. The electronic plan of care was reviewed for the resident and it stated that the resident is to be provided 6 g (1 scoop) protein powder three times daily at meals; in oatmeal at breakfast, in soup at lunch, in fruit juice at supper. In addition, the plan of care did not indicate that the resident is a late riser.

Resident #25
April 22, 2014 – Resident #25 was brought into the dining room by staff at 9:45am. The resident was not offered a choice of foods and was provided cold cereal and toast. No egg was available. The resident's plan of care did not outline that the resident is a late riser.

Resident #26
April 23, 2014 – Resident #26 was in the dining room eating breakfast at 9:38am and was overheard by the LTCH Inspector to ask for water at 9:48am stating that the resident found the air dry. The resident further stated that there was no water at the table. The LTCH Inspector noted that the resident did not have any beverages to drink. The resident again asked for water several minutes later when a PSW was in the resident's vicinity but nothing was provided. At 9:55am the resident was being removed from the dining room by the RPN. The LTCH Inspector intervened and directed the RPN to provide the resident a beverage as the LTCH Inspector had already determined from the previous day that not all residents are not offered a mid-morning beverage.

Resident #27
April 23, 2014 – Resident #27 was brought to the dining room at 10:02am by staff and provided apple juice and water, cold cereal and milk. No milk as a beverage was provided to the resident as instructed by the resident's plan of care. The LTCH Inspector spoke with the resident on April 25, 2014 and the resident stated that he/she prefers to get up early in the morning as he/she had always been an early riser. The resident stated that he/she is unable to get up him/herself up and must wait for staff to come get him/her. The LTCH Inspector spoke with a PSW on the unit, Staff #124, who stated that the resident is awake in bed when staff go to get the resident up at 8:50 am and is usually voicing that he/she is hungry.

The following resident specific observations were made by LTCH Inspector #138 at breakfast the mornings of April 24 and 25, 2014 on Wexford House:

Resident #11
April 24, 2014 – Resident #11 was observed with a bowl of cereal, sitting at the dining room table at 8:37am. The resident was not eating and had his/her eyes closed. Verbal encouragement to eat was provided to the resident at 8:48am but was not effective. At 9:10am, the resident was still not eating and no assistance was provided. The weight record was reviewed and it was observed that the resident has a recent history of undesirable weight loss.

Resident #12
April 24, 2014 – LTCH Inspector overheard Resident #12 express frustration to tablemates at 9:37am about the lack of service in the dining room. Resident 312 further stated that he/she had finished his/her cereal and wanted the rest of his/her breakfast. At 9:45am, the RPN took the resident's order for eggs and toast. Toast only was provided to the resident at 9:58am as the eggs were no longer available. The LTCH Inspector spoke with Resident #12 who stated that he/she was frustrated with morning care because he/she is dependent on staff to get up in the morning and if staff were late in getting him/her up from bed than he/she could not get to the dining room before the hot food was gone.

Resident #13
April 24, 2014 – Resident #13 was assisted to the dining room table at 9:35am and was not offered anything to eat until fifteen minutes later when the resident was provide cold cereal followed by toast. The resident was not offered any choice and no eggs were available. The resident's plan of care did not indicate that the resident was a late riser.

Resident #14
April 24, 2014 – Resident #15 was assisted to the dining room at 9:45am. The resident was offered hot cereal but there was none in the dining room and instead was provided cold cereal and toast. Again no eggs were available. The resident's plan of care did not indicate that the resident was a late riser.

Resident #10
April 24, 2014 - Resident #10 was observed in the dining and finished his/her cereal prior to 9:30am. The resident was not provided the remaining portion of his/her

breakfast meal until almost thirty minutes later. Eggs were not available or offered to the resident.

Resident #35
April 24, 2014 – Resident #35 was assisted to the dining room at approximately 9:30am and was only offered cold cereal and toast. The resident stated that he/she wanted eggs but was declined by staff. Resident #35 was verbally upset that he/she could not have eggs.
April 25, 2014 – Resident #35 was again assisted to the dining room at approximately 9:30am. After eating his/her cereal, Resident #35 requested eggs but was told by staff that none were available. The resident asked for eggs again several minutes later and was again told no.
The resident's plan of care did not indicate that the resident was a late riser.

Resident #28
April 24, 2014 – Resident #28 was brought into the dining room at 9:50am and staff reheated a bowl of hot cereal and provided toast to the resident. No eggs were available to the resident. The resident's plan of care did not indicate that the resident was a late riser.

Resident #29
April 24, 2014 – Resident #29 was brought into the dining room at 9:53am.
April 25, 2014 – Resident #29 was brought into the dining room at 10:00am.
Resident #29's plan of care did not indicate that the resident was a late riser.

Resident #9
April 24, 2014 – Resident #9 was brought into the dining room at 10:08am and provided cold cereal that he/she did not eat. The resident was then provided toast and cheese at 10:15am which the resident did not eat. The resident was not provided assistance with the breakfast meal and was observed at 10:43am with the toast and cheese in front of Resident #9 not eaten.
April 25, 2014 Resident #9 was observed with cold cereal sitting in front of his/her at 8:55am. The nutritional service aide provided the resident verbal encouragement twice but the verbal encouragement was ineffective and the resident was not eating. The nutritional service aide provided the resident a waffle at 9:35am but the resident did not eat. Minutes later, the resident's family member came into the dining room and provided physical assistance to the resident which was effective.
The plan of care for the resident states that the resident is high nutritional risk and

requires one person to assist with eating. The plan of care further stated that Resident #9 was to receive fortified hot cereal at breakfast, with raisin toast and half a banana which the resident did not receive. Further, the resident's care plan did not indicate that the resident was a late riser.

Resident #30
April 25, 2014 – Resident #30 was observed in the dining room at 8:55am with a bowl of hot cereal and a glass of apple juice. The resident was attempting to fed self but was having obvious difficulty. The resident continued to struggle to feed self until 10:05am, an hour and ten minutes later when a PSW sat with the resident to provide the resident some toast. No egg was offered to the resident as none was available. The resident's care plan states that the resident requires extensive assistance with meals and that straws are to be used with beverages. No straws were provided to the resident.

Resident #31
April 25, 2014 – Resident #31 was assisted to the dining room at 10:12am and provided a meal. The resident's plan of care states that the resident is to have prune juice at the breakfast meal. Prune juice was available in the dining room but not offered to the resident. Further, Resident #31's care plan did not indicate that the resident was a late riser.

Resident #29
April 24, 2014 – Resident #29 was brought to the dining room at 9:53am.
April 25, 2014 – Resident #29 was brought to the dining room at 10:00am.
Resident #29's plan of care did not indicate that the resident was a late riser.

Resident #17
April 25, 2014 – Resident #17 was brought to the dining room at 9:40am and was not provided a meal until over thirty minutes later when the resident was provided cold cereal and milk. The resident was assisted with his/her cereal but no other food was offered to the resident including toast. The resident's plan of care states that the resident is high nutritional risk, underweight and has a history of weight loss. Further, the care plan does not indicate that the resident was a late riser.

Resident # 37
April 25, 2014 – LTCH Inspector #138 observed Resident #37 being assisted by a tablemate at 9:23am. The tablemate stated to LTCH Inspector that Resident #37 was

blind and needed assistance with meals. It was noted by the LTCH Inspector that staff did not provide assistance to Resident #37 in eating his/her meal. Resident #37's plan of care stated that the resident had limited abilities to complete activities of daily living due to blindness and cognitive impairment and that the resident required assistance with eating.

In addition to the identified concerns with the breakfast routine on Waterford House and Wexford House, it was observed that the licensee failed to offer all resident on these two units with a mid-morning beverage in accordance with O. Reg 70/10 section 71 (3) (b).

LTCH Inspector #138 was on Waterford House on April 22, 2014 and monitored resident care from 8:35am through to the set up of the lunch meal after 11:45am. The LTCH Inspector did not observe that beverages were offered or provided to all residents between breakfast and the lunch meal. The LTCH Inspector spoke with the RPN, Staff #104, who stated that the morning between meal beverages would be provided if a resident asked for one. The LTCH Inspector noted that there were several residents on Waterford House who are not capable of asking for beverages.

LTCH Inspector #138 arrived on Waterford House the following day on April 23, 2014 at 9:20am and monitored resident care through to the set up of the lunch meal service. It was observed again by the LTCH Inspector that beverages were not offered or provided to all residents.

LTCH Inspector #138 proceeded to Wexford House on April 24, 2014 and arrived on the unit at 8:30am. The LTCH Inspector stayed on the unit until 11:30am to monitor resident care. It was observed by the LTCH Inspector that not all residents were offered or provided a mid-morning beverage. The LTCH Inspector spoke with a PSW, staff #116, who stated that residents would only be provided a mid-morning beverage if they requested a beverage. It was observed by the LTCH Inspector that, like Waterford House, Wexford House had several residents who are not capable of asking for a beverage.

LTCH Inspector #138 arrived on Wexford House at 8:55am and monitored resident care until the noon lunch meal was underway. It was observed by the LTCH Inspector that mid-morning beverages were not offered or provided to all residents on Wexford House that morning. The LTCH Inspector spoke with the RPN, Staff # 121, who stated that a mid-morning beverage pass was not a usual part of the unit's morning

routine.

While LTCH Inspector #138 was monitoring care on Waterford House on April 22, 2014 it was noted that two residents were placed in the lounge across from the dining room and were not released from their physical device or repositioned in accordance with O. Reg 79/10 section 110. (2) 4.

Specifically, LTCH Inspector #138 was on Waterford House the morning of April 22, 2014 and observed, prior to 9:07am, that Resident #2 and Resident #4 were seated in the lounge across from the dining room. Resident #2 was observed in a wheelchair with a lap belt and a table top in place on the wheelchair. Resident #4 was also observed in a wheelchair and was wearing a lap belt. LTCH Inspector #138 continued to observe these two residents until 11:45am. The LTCH Inspector did not observe that Resident #2 was released from the lap belt or table top and repositioned nor was Resident #4 released from the lap belt and repositioned. The duration of time the residents were observed was more than two and a half hours.

Discussion was held with the RN for the fifth floor, Staff #125, on April 28, 2014 regarding the LTCH Inspectors observations about the morning care provided on fifth floor. Staff #125 stated that the morning care is very challenging and that staff are not able to get all the residents up in time for breakfast. She further stated that the residents who are taken to the dining room late for breakfast are late because of staff and not because of the residents' wish to be a late riser. She further stated that the staff continue to discuss alternatives to rectify the concerns.

Discussion was held with the VP Resident Care on April 29, 2014 regarding the provision of care in the mornings on the fifth floor. The VP Resident Care stated that she is aware of the challenges on fifth floor. She stated that one of the strategies being worked on in the home is to ensure consistent staffing on the unit so that staff are familiar with the care needs of the unit. (s.8)

***Additional Required Actions:***

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

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

The licensee failed to comply with LTCHA s. 31 (1) in that several residents were restrained by a physical device as described in paragraph 3 of subsection 30 (1) and their plans of care did not meet all of the provisions and requirements for restraining by physical devices.

During the Resident Quality Inspection conducted at St Patrick's Home form April 14 to the 29, 2014, the following areas of non-compliance were identified related to the consent, application, monitoring, reassessment and removal of restraints and that their use was not documented as per legislated provisions and requirements under LTCHA s. 31 (2) and (3).

1) The LTCHA s. 31 (2) 5) states the following: The restraining of residents has not been consented to by the resident, if the resident is incapable, a substitute decision maker of the resident with authority to give that consent. This is issued under WN # 02 in the Inspection Report.

A) The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 31 (5) in that the restraining of two residents have not been consented to by the residents or, if the residents are incapable, by their substitute decision-maker with authority to give that consent.

i) Resident #740 was admitted to the home in December 2012. A physician's order dated on a specific day in June 2013 indicates Resident #740 is to have a safety belt with a ten pound clasp applied when up in wheel chair. A fall risk assessment completed on an identified day in July 2013 indicates that Resident #740 is at a high risk for falls.

A review of the Resident's medical record indicates that physical restraint use is

included in the resident's care plan. The care plan also states that a valid consent is to be on the chart prior to initiating the use of the restraint.

A review of the homes policy entitled Restraints: Use of Least Restraints Part II-L29 with a revision date of October 15, 2011 states that the prescribing clinician should ensure that an informed consent is obtained for the treatment from the resident and/or the substitute decision-maker.

A review of the home's mandatory annual staff education material currently used by the home states that informed consent must be obtained for the use of restraints.

Registered staff member #S118 reviewed the resident's medical record with Inspector #556 and could not locate a signed consent. Staff member #S118 stated that there is supposed to be a signed consent for every restraint. The licensee has failed to obtain consent from Resident #740 or the Resident's Substitute Decision Maker for restraint by a physical device.

ii) Resident #21 was admitted to the home on a specified day in February 2014. The resident is noted to have cognitive impairments and his/her family member is the designated substitute decision maker.

Chart documentation indicates that at the time of admission, the resident's family member informed the home that the resident is to have his/her wheelchair lap belt applied at all times as Resident #21 is at high risk for falls. The family member reported that Resident #21 had sustained a fall with injuries two days prior to his/her admission. On the day of admission in February 2014, the attending physician wrote an order for a wheelchair lap belt to be applied for safety when the resident is up in wheelchair.

Interviewed registered staff members S#152 and S#149 stated to Inspector #117 that the resident was not able to undo the lap belt by him/herself and therefore the lap belt was a restraint. They report that the lap belt was applied when the resident was up in his/her wheelchair. No consent, verbal or written, for the use of wheelchair lap belt found in resident's chart

2) The LTCHA s. 31 (3) states the following: If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that: (b) the resident is

monitored while restrained, in accordance with the requirements provided for in the regulations; (c) the resident is released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations; (d) the resident's condition is reassessed and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations; (g) any other requirements provided for in the regulations are satisfied.

The following findings of non-compliance are issued under O.Reg. 79/10 s. 110 WN # 22 of the Inspection Report.

i. The licensee failed to comply with O. Reg 79/10 section 110 (1) 1 in that the licensee failed, with respect to the restraining of a resident by a physical device under section 31 of the Act, to ensure that staff apply the physical device in accordance with any manufacture's instruction.

i) On April 23, 2014 Inspector #556 observed Resident #740 sitting in a wheel chair in the dining room with a seat belt applied six inches too loose.

A review of the resident's medical record indicates there is a physician's order dated on a specific day in June 2013 for wheel chair with safety belt with a ten pound clasp.

A review of the homes policy entitled Restraints: Use of Least Restraints Part II-L29 with a revision date of October 15, 2011 states Care Plan is to outline specific steps for applying and reapplying the device according to instructions given in the order and to manufacturer's instructions and specifications; specify instructions in the care plan.

A review of the resident's care plan indicates that physical restraint use is included in the resident's care plan however there is no indication of how the restraint device is to be applied.

Staff member #S130 who gave morning care to Resident #740 on April 23, 2014 stated that the seat belt was about five or six inches too loose but the seat belt was stuck and could not be tightened. Staff member #S130 further stated Resident #740 doesn't move, and while it's not good for the seat belt to be loose like that, the resident stays put and is therefore not at risk. She stated that the seat belt does need to be applied because it is part of the resident's care plan.

Registered staff member #S120 observed the seat belt on the resident and stated that there should only be room to put a flat hand between the resident and the seat belt and proceeded to tighten the seat belt on Resident #740 while Inspector #556 was present. Registered staff member #S120 further stated that the seat belt had not been applied correctly.

ii) On April 15, 2014 Inspector 573 observed resident #620 sitting in a Broda wheel chair with a lap belt that was not positioned across the hips and had more than approximately 7 inches between the belt and pelvic crest.

iii) On April 16, 2014 Inspector 573 observed resident #615 sitting in a wheel chair with a 4 point lap belt the outer one strap is not secured properly, the lap belt was also observed to be loose as evidenced by a greater than 10 inches between the belt and pelvic crest.

On April 29, 2014 the Licensee contracted occupational therapist confirmed during an interview with Inspector #573 that the wheel chair seat belt has to be applied properly. Definitely not too tight or loose, there should be a finger width space between the belt and the hips, the seat belt has to be snug fit so that it prevents residents sliding out from the wheel chair.

iv) On April 22, 2014, LTCH Inspector #138 observed Resident #3 seated in a wheelchair with a lap belt applied loosely over the resident's hips. The LTCH Inspector noted that the lap belt could be pulled four to six inches away from the resident's body. LTCH Inspector #138 spoke with the unit RPN, Staff #104, who examined the resident's lap belt and agreed that it was too loose. Staff #104 worked with Staff #102 to readjust the resident's lap belt so that it properly fit the resident.

v) On April 24, 2014, LTCH Inspector #138 was observing a breakfast meal service and observed that Resident #17 was in a wheelchair with a lap belt applied very loosely around the hips. Upon further observation, the LTCH Inspector noted that the lap belt could be pulled six to seven inches away from the resident's body. LTCH Inspector #138 spoke with the unit RPN, Staff #15, who examined Resident #17's lap belt and stated that she agreed that it was too loose. Staff #17 stated that she would call to have someone come and adjust the lap belt to fit the resident properly. LTCH Inspector #138 followed up the next day and noted that the resident's lap belt was properly fitting.

B) The licensee failed to comply with O.Reg 79/10, s.110 (2) (6) in that the resident's condition was not reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

i. Resident #555 has advanced dementia, is identified as being at high fall risk and has a lap belt front buckle restraint as a fall prevention intervention.

A review of the resident's health care record was conducted by Inspector #117. It was noted that the resident's current plan of care identifies that the resident has a lap belt restraint. However no documentation was found related to the monitoring of the application, the repositioning and the removal of the resident's lap belt restraint. Also no information related to the assessment of the resident's condition and the effectiveness of the restraining was noted to be evaluated by a member of the registered nursing staff, at least every eight hour.

Staff member S#106, reviewed the resident's health care record with Inspector #117 on April 22, 2014. She stated to that she was not aware of any process for registered nursing staff to monitor resident's condition when a restraint is applied. Also, S#106 stated that she could not find any documentation in the resident's record indicating that when staff apply the resident's lap belt, when the resident is being repositioned and the lap belt removed.

C) The licensee failed to comply with O. Reg 79/10 section 110. (7) (5, 6, 7 and 8) in that the licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented.

i. Resident #555 has advanced dementia, is identified as being at high fall risk and has a lap belt front buckle restraint as a fall prevention intervention.

A review of the resident's health care record was conducted by Inspector #117. It was noted that the resident's current plan of care identifies that the resident has a lap belt restraint. However, no documentation was found related to the application of the lap belt restraint; the assessment, reassessment and monitoring, including the resident's response; the release of the device and all repositioning; as well as the removal of the

resident's lap belt restraint.

Staff member S#106, reviewed the resident's health care record with Inspector #117 on April 22, 2014. Restraint initiation/monitoring/documentation flow sheets were found for the months of January, February and March 2014. The March 2014, flow sheet indicates that on 15/31 day shifts and on 6/31 evening shifts there is no documentation related to the application / monitoring / repositioning and removal of Resident #555's lap belt.

No information was found related to the application / monitoring / repositioning and removal of Resident #555's lap belt for the month of April 2014. S#106 stated that she could not find any documentation in the resident's record indicating that nursing staff were currently documenting the application / monitoring / repositioning and removal of Resident #555's lap belt.

ii. Resident #21 was admitted on a specified day in February 2014. It is noted that the resident had previously been admitted to the home in late November 2013. At the time of the resident's admission, the resident's family member informed the home's Admission Coordinator S#152 that the resident had sustained several falls in the past few weeks, including a fall, with bruising injuries, that had occurred two days prior to Resident #21's February admission. The resident's family member also informed the home's Admission Coordinator that when the resident is seated in his/her wheelchair, the wheelchair lap belt restraint needs to be applied at all times due to the resident risk for falls. This information was given to Inspector #117 by the resident's family member on April 23, 2014 and confirmed that same day with the Admissions Coordinator S#152. Progress notes document that four days after his/her admission, Resident #21 fell out of the wheelchair as the lap belt had not been applied

A review of Resident #21's health care record was conducted in the presence of S#152 on April 24, 2014. No plan of care and no Restraint Initiation / Monitoring / Repositioning record was found in the resident's chart. On April 24, 2014, staff members S#149 and S#150 stated to Inspector #117 that they did provide care to Resident #21 during his/her stay at the home. However, there is no documentation found in the resident's chart related to the application, monitoring, repositioning and removal of the resident's lap belt. (log #O-000215-14)

D) The licensee failed to comply with O. Reg 79/10 section 110. (7) (5 and 7) in that

the licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented.

i. LTCH Inspector #138 reviewed the health care record for Resident #2 and Resident #4 after observing that both residents had not been released from their restraints and repositioned in accordance with O. Reg 79/10 s. 110, (2) 4 on April 22, 2014. The current care plan for Resident #2 stated that the resident was to be in a tilt wheelchair with a lap belt and a table top on the wheelchair as a physical restraint and the current care plan for Resident #4 stated that the resident was to wear a lap belt as a physical restraint.

Staff member S#102 stated to LTCH Inspector #138 that the documentation of all restraints was completed by the PSWs on the Restraint Monitoring Record found in the flow sheet binder for the residents. The LTCH Inspector reviewed the flow sheet binder and observed for Resident #2 that the Restraint Monitoring Record was not consistently completed in that twenty five of the forty two required entries for April 1 - 21, 2014 regarding restraint use were left blank. The LTCH Inspector was unable to locate a Restraint Monitoring Record for Resident #4.

ii. On April 24, 2014, LTCH Inspector #138 observed during a meal observation that a lap belt applied to Resident #17 was not applied in accordance with O. Reg 79/10 section 110 (1) 1. The LTCH Inspector reviewed the resident's health care record and noted that the resident is planned to wear a physical restraint.

LTCH Inspector #138 spoke with staff member S#122, regarding the documentation of application and release of restraints. Staff member S#122 stated that the documentation is completed by the PSW's on the Restraining Monitoring Record but stated that this documentation is a current challenge for the home and acknowledged that it is not consistently completed and that the Restraining Monitoring Record may not even be able for documentation.

E) The licensee has failed to comply with O.Reg. 79/10, s. 110 (8) (5) in that the release and repositioning of Resident #740 from a physical device was not documented on ten separate shifts in April 2014 no documentation was completed.

i. A physician's order dated on a specific day in June 2013 indicates Resident #740 is to have a safety belt with a ten pound clasp applied when resident is up in wheel chair.

A review of Resident #740's care plan indicates that staff are to check resident and release restraint as per facility protocol.

A review of the homes policy entitled Restraints: Use of Least Restraints Part II-L29 with a revision date of October 15, 2011 states the interdisciplinary team is to document every hour on the restraint monitoring record and every two hours when the restraint is released and the resident is repositioned.

A review of the Restraint Monitoring Record for April 2014 on Resident #740's medical record indicates that on 6 day shifts in April and on four evening shifts in April there was no documentation to indicate that Resident #740 had been released and repositioned at least once every two hours, however progress notes on each of those days indicate that the resident was present in the home.(s.31)

***Additional Required Actions:***

***CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

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

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**Findings/Faits saillants :**

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

Resident #555 is identified as having advanced dementia. Resident #555 was observed by Inspector #117 to have long facial hair and long jagged nails on April 14, 15, 16, 17 and 22, 2014. Staff members S#107 and S#108 as well S#106 stated to Inspector #117 on April 22, 2014, that Resident #555 is very resistive to the provision of personal. They report that the resident will become agitated and physically aggressive towards staff who provide direct personal care. They report that shaving and grooming supplies are not readily available to ensure facial grooming and nail care. Resident #555's current plan of care does identify that the resident requires extensive staff assistance for his/her daily hygiene and grooming. However, it does not identify that the resident is resistive to personal care, hygiene and grooming. It also does not identify any other redirection interventions to ensure the provision of personal care.

Resident #555 plan of care does not set out clear direction to staff and others who direct care to the resident to ensure that the resident receive hygiene and grooming as per her care needs. [s. 6. (1) (c)]

2. A review of Resident #740's plan of care indicates that the resident is to use a physical restraint for safety due to poor judgement, cognitive loss, and CVA, however the care plan does not indicate what type of restraint is to be applied.

The kardex in the binder used by the front line staff states Resident #740's trunk restraint and chair prevents rising but does not indicate what kind of trunk restraint is to be applied.

In an interview full time staff member #S130 stated that if she was new and didn't know the resident she would look at the care plan to determine what kind of restraint to use on the resident, however when staff member #S130 looked at the kardex and the care plan she stated that the kardex indicates a trunk restraint should be applied but not what kind of trunk restraint. Staff member #S130 further stated that if she was a new hire she would not have clear direction as to what type of restraint Resident #740 requires.

Registered staff #S118 reviewed the care plan for Resident #740 with Inspector #556 and stated that the care plan should clearly specify what type of restrain is required by the resident. [s. 6. (1) (c)]

3. Resident #560 was observed during stage 1 of the RQI to have very long and un-groomed facial hair on his/her upper lip and chin. When approached regarding his/her personal grooming, Resident #560 informed Inspector #117 that only a specific family member is allowed to assist with his/her personal care. At the same time, it was noted that the resident's call bell was looped and attached with twist ties to the resident-staff communication system console on the wall.

On April 23, 2014, staff member S#154 stated to Inspector #117 that the resident does require limited 1-person assistance with his/her personal care and grooming. She reports that the resident is resistive to any assistance with his/her grooming. She also reports that the resident's call bell is looped and attached to the wall console as the resident does not like to have anything on his/her bedding or clipped to his/her furnishings. This information was confirmed by the unit staff members S#112 and S#109.

A review of the Resident #560's plan of care identifies that the resident has cognitive impairments. It also notes that staff need to verify and ensure that the resident's personal hygiene and grooming is done on daily basis. However the plan does not identify any interventions staff are to use to ensure that the resident's grooming needs are met. It also does not identify the resident's preferences and use of the resident-staff communication system in his/her room. Resident #560's plan of care does not give clear direction to staff on how to assist the resident with his/her hygiene, grooming and preferences related to the call bell system [s. 6. (1) (c)]

4. On April 22, 2014, LTCH Inspector #138 noted that Resident #3's lap belt was not applied in accordance with O.Reg 79/10 section 110 (1) 1 and discussed the observations with Staff #102. Staff #102 stated that she was not sure if Resident #3 was even suppose to wear a lap belt and proceeded to verify with the unit RPN who confirmed that the resident was to wear a lap belt. The LTCH Inspector reviewed Resident #3's plan of care which, as directed by Staff #102, are contained in a binder on the unit. The plan of care reviewed did not provide any information relating to the application of a lap belt for the Resident #3. It was observed by the LTCH Inspector that the plan of care in the electronic health care record, PointClickCare, did outline information related to the application of a lap belt for Resident #3 however Staff #113 stated that the PSWs do not have access to the electronic plans of care and must use the printed versions that are located in the binders on the units.

On April 22, 2014, LTCH Inspector #138 noted that Resident#1's lap belt was not

applied in accordance with O.Reg 70/10 section 111 (2) (b). After notifying Staff #104 who reapplied the lap belt correctly, the LTCH Inspector reviewed the plan of care contained in the binder on the unit and noted that the plan of care did not provide any direction to staff regarding the use of a lap belt for the resident. The LTCH Inspector also viewed the electronic plan of care and noted that there was no direction relating to the use of a lap belt for the resident. [s. 6. (1) (c)]

***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 identified residents plans of care give clear direction to staff as it relates to the following: the use of restraints, lap belts, grooming and use of resident-staff communication system, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan**

**Specifically failed to comply with the following:**

**s. 24. (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 79/10, s. 24 (1).**

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**Findings/Faits saillants :**

1. The licensee failed to comply with O.Reg. 79/10, s.24 (1) in that a 24-hour care plan was not developed for a resident and communicated to direct care staff within 24-hours of the resident's admission to the home.

Resident #21 was admitted on a specified day in February 2014. It is noted that the resident had previously been admitted to the home in late November 2013. At the time of the resident's admission, the resident's family member informed the home's Admission Coordinator S#152 that the resident had sustained several falls in the past few weeks, including a fall, with bruising injuries, that had occurred two days prior to Resident #21's admission. The resident's family member also informed the home's Admission Coordinator that when the resident is seated in his/her wheelchair, the wheelchair lap belt restraint needs to be applied at all times due to the resident risk for falls. This information was given to Inspector #117 by the resident's family member on April 23, 2014 and confirmed that same day with the Admissions Coordinator S#152.

A review of Resident #21's health care record was conducted in the presence of S#152 on April 24, 2014. No plan of care was found in the resident's chart. On April 24, 2014, staff members #149 and S#150 stated to Inspector #117 that they did provide care to Resident #21 during his/her stay at the home. However, they report that they do not recall seeing any plan of care for the resident and that they did not receive any clear direction related the resident's fall risk and use of a lap belt restraint. They also report that they did not have any information as to the resident's daily care needs other then he/she required a mechanical lift for transfers and required total assistance with his/her personal care. It was noted that during the previous stay at the home, the resident did have a plan of care within 24-hours of his/her admission. This plan of care was not brought forward, or revised to include the resident's current care needs.

Nursing staff did not ensure that a 24-hour plan of care was developed and communicated to direct care staff within 24-hours of Resident #21 admission for short stay respite. (log #O-000251-14) [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 a 24-hour plan of care be developed for residents who are admitted for short stay respite and that this be communicated to direct care staff within 24-hours of the residents short stay respite admission, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.**

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**Findings/Faits saillants :**

1. The licensee failed to comply with O.Reg 79/10, s. 32 in that the home did not ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis.

Resident #555 is cognitively impaired. Resident #555 was observed, by Inspector #117, on April 14, 15, 16 , 17 and 22, 2014, to have long jagged nails and long facial chin hairs. On April 22, 2014, staff member S#106 stated to Inspector #117 that the resident is very resistive to care, that he/she becomes agitated when staff provide daily hygiene and grooming, including facial and hand hygiene. The staff member S#106 stated that she had not noticed Resident #555's facial hair and long jagged nails. Staff members S#107 and S#108 stated that they do not try to cut resident's facial hair and nails due to his/her agitation and resistance to care during provision of personal care. All three staff members were not aware of any alternative interventions that would be provided to the resident to ensure that he/she does receive grooming care. [s. 32.]

2. Resident #560 was observed during stage 1 of the RQI to have very long and un-groomed facial hair on the upper lip and chin. When approached regarding his/her personal grooming, Resident #560 informed Inspector #117 that only a specific family member is allowed to assist with his/her personal care.

On April 23, 2014, staff member S#154 stated to Inspector #117 that the resident does require limited 1-person assistance with his/her personal care and grooming. She reports that the resident is resistive to any assistance with his/her grooming. This information was confirmed by the unit registered staff S#112 and S#109. A review of the Resident #560's plan of care identifies that the resident has cognitive impairments. It also notes that staff need to verify and ensure that the resident's personal hygiene and grooming is done on daily basis. However the plan does not identify any interventions staff are to use to ensure that the resident's grooming needs are met. [s. 32.]

3. Resident #21 was admitted to the home on a specific day in February 2014. The resident has cognitive impairments and neurodegenerative disease. He/She requires full staff assistance for the provision of personal care.

On April 24, 2014, Resident #21's family member, stated to Inspector #117, that on a specific day in March 2014, he/she noted that the resident was unshaven when he/she came to visit the resident. The family member stated that he/she had been approached by S#106, to bring a razor for the resident so that nursing staff could shave and groom Resident #21 as the home did not provide razors or shaving supplies to residents. This information was confirmed by S#152 on April 25, 2014.

On April 25, 2014 staff members S#149 and S#150 stated to Inspector #117 that they were are unable to provide grooming assistance for Resident #21 during his/her stay at the home as the resident did not have an electric razor and the home does not have any other type of razors or shaving supplies to assist with the grooming of the residents. (log #O-000251-14) [s. 32.]

4. On April 25, 2014, residents #32, #33, #34 and #611 were noted to have long facial hair that was unshaven and un-groomed. The residents' plan of care identified that the residents required 1-staff assistance for personal care and grooming due to their various physical impairments. The residents stated to Inspector #117 that they would like to be shaved but staff are unable to shave them as their electric razors are broken.

On April 25, 2014 staff members S#149 and S#150 stated to Inspector #117 that they are unable to provide grooming assistance for these residents as the residents electric razors are non-functional and the home does not have any other type of razors or shaving supplies to assist with the grooming of the residents. They report that they

are not aware of any other available grooming supplies to assist the residents with their grooming needs.

Staff member S#117, who oversees the ordering of supplies in the home, stated on April 25, 2014, that for the past 3-4 years she has not ordered any razors or shaving supplies for residents. The home's Vice President of Resident Care Services confirmed that the home does not provide any razors or shaving supplies to residents. The Vice President stated that the home did have some common use electric razors, prior to the move to the new building but is unaware if these were brought over to the new building to provide grooming assistance for residents with no personal electric shavers.

The home did not ensure that Residents #21, #555, #560, #32, #33, #34 and #611 receive grooming assistance on a daily basis. [s. 32.]

***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 who require assistance with personal grooming and shaving, receive assistance on a daily basis, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.**

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**Findings/Faits saillants :**

1. The licensee failed to comply with O.Reg 79/10, s. 44 in that the home did not ensure that supplies, equipment and devices were readily available at the home to meet the nursing and personal care needs of residents.

On April 24, 2014, Resident #21's son, stated to Inspector #117, that on March 3, 2014, he noted that his was unshaven when we came to visit his father. The son stated that he had been approached by RPN S#106, to bring a razor for his father so that nursing staff could shave and groom Resident #21 as the home did not provide razors or shaving supplies to residents. This information was confirmed by RPN S#152 on April 25, 2014.

On April 25, 2014, residents #32, #33, #34 and #611 were noted to have long facial hair that was unshaven and un-groomed. The residents stated to Inspector #117 that they would like to be shaved but staff are unable to shave them as their electric razors are broken. They report that staff does not have any shaving supplies to provide grooming assistance.

Inspector #117 examined clean utility rooms and grooming supplies on several resident care units. No razors or shaving supplies were noted to be present on resident care units.

On April 25, 2014, RPN S#152, RN S#118, RN S#119 , PSWs S#149, S#150 and S#151 stated to Inspector #117 that home does not provide any razors or shaving supplies to residents. They report that the home has a policy that staff are to shave residents only with electric shavers and that it is the residents / substitute decision makers responsibility to provide electric razors and shaving supplies. The home's ward clerk S#117, who oversees the ordering of supplies in the home, stated on April 25, 2014, that for the past 3-4 years she has not ordered any razors or shaving supplies for residents. The home's Vice President of Resident Care Services confirmed that the home does not provide any razors or shaving supplies to residents. The Vice President stated that the home did have some common use electric razors, prior to the move to the new building but is unaware if these were brought over to the new building to provide grooming assistance for residents with no personal electric shavers.

The home did not ensure that there are available razors and grooming supplies to meet the grooming and shaving needs of residents in the home. [s. 44.]

***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 razors and shaving supplies be available for residents grooming needs as required by the LSAA agreement, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

**Specifically failed to comply with the following:**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:**
**6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).**

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**Findings/Faits saillants :**

1. The licensee failed to comply with O. Reg 79/10 section 73 (1) 6 in that the licensee failed to ensure that the dining service includes foods and fluids being served at a temperature that is both safe and palatable to residents.

Stage 1 of the Resident Quality Inspection involves several activities including the interviewing of randomly selected residents (where appropriate) and the interviewing of several family or significant others about the care and services of the home. From the information collected, food quality relating to food temperatures (hot food not being hot enough) was triggered as a concern for further inspection during Stage 2 of the Resident Quality Inspection.

During Stage 2, LTCH Inspector #138 observed the lunch meal on April 23, 2014 on Cavan House. Towards the end of the meal the LTCH Inspector interviewed six residents about the meal service. Five of the six residents interviewed stated that the food at the lunch meal service that day was too cold. Resident #18 further stated that he/she is trying to gain weight but that he/she could not eat the food at the lunch meal because it was too cold. The resident further stated that the staff put lukewarm food on plates that are not heated or warmed which causes the food to cool even further.

The LTCH Inspector noted that Resident #18's meal was only partially eaten and that there was no offer by staff to reheat the meal or offer the resident another choice. The general consensus of the five residents interviewed was that the food in the home is generally good but can be too cold some days.

LTCH Inspector #138 spoke with the unit nutritional service aide, Staff #148, regarding food temperatures. Staff S#148 stated that food temperatures are taken prior to service and recorded. Staff #148 stated that the temperatures are usually good but that there are some days at lunch specifically were the hot temperatures are only at the minimum requirement. The LTCH Inspector reviewed the Hot Cart and Cold Food Temperature Log sheet that was provided by Staff S#148 for the lunch meal and noted that hot food temperatures were recorded predominately at 140 degrees Fahrenheit. The reverse side of the sheet states that hot food must be kept at a minimum of 140 degrees Fahrenheit and that corrective action will only occur if the food temperature for hot food falls below 140 degrees Fahrenheit.

Discussion was held with the Food Service Supervisor and the Manager of Support Services regarding the complaints from resident about the food being too cold. Specifically, it was discussed that food temperatures can affect taste intensity for residents and that food is required to be served at a preferable temperature as discerned by the residents in the home. This preferable temperature should not be confused with safe holding temperature guidelines as 140 degrees Fahrenheit, while appropriate for holding hot food safely to prevent food borne illness, is often considered lukewarm. [s. 73. (1) 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 foods and fluids are served at a temperature that is both safe and palatable, to be implemented voluntarily.***

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal**

**Specifically failed to comply with the following:**

**s. 136. (1) Every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of,**
**(a) all expired drugs; O. Reg. 79/10, s. 136 (1).**
**(b) all drugs with illegible labels; O. Reg. 79/10, s. 136 (1).**
**(c) all drugs that are in containers that do not meet the requirements for marking containers specified under subsection 156 (3) of the Drug and Pharmacies Regulation Act; and O. Reg. 79/10, s. 136 (1).**
**(d) a resident's drugs where,**
**(i) the prescriber attending the resident orders that the use of the drug be discontinued,**
**(ii) the resident dies, subject to obtaining the written approval of the person who has signed the medical certificate of death under the Vital Statistics Act or the resident's attending physician, or**
**(iii) the resident is discharged and the drugs prescribed for the resident are not sent with the resident under section 128. O. Reg. 79/10, s. 136 (1).**

**s. 136. (3) The drugs must be destroyed by a team acting together and composed of,**
**(b) in every other case,**
**(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and**
**(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).**

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**Findings/Faits saillants :**

1. The licensee failed to comply with O.Reg. 79/10, s. 136 (1) in that the home's written policy related to the ongoing identification, destruction and disposal of medication does not include the directives for the destruction of medication that are not designated under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act.

During a review of the home's medication management system, Inspector #117 reviewed the home's policies related to medication destruction. The home has a policy named Administration of and Control of Narcotics, # IX NSG G-25.00, dated October 2013 The policy does identify the home's process for the ongoing identification, destruction and disposal of narcotics and controlled drugs and

substances.

The home also has a policy named Medication Reconciliation policy IX NSG G-32.00 , reviewed October 2013. There is no information noted in this policy related to medication destruction and disposal for any medication, be it regular medication or controlled drugs.

On April 25, 2014, the Vice President of Resident Care reviewed the home's medication destruction and disposal policy with Inspector #117. She did confirm that although the home does have a policy related to narcotics, controlled drugs and substances, she was not aware that the home did not have a policy related to the destruction/ denaturing and disposal of all other medication. [s. 136. (1)]

2. The licensee failed to comply with O.Reg. 79/10 , s. 136. (3) in that the home's drugs are not destroyed by a team acting together and composed of, (a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada), (i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and (ii) a physician or a pharmacist; and (b) in every other case, (i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and (ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

On April 24 and 25, 2014, Inspector #117 conducted a review of the home's medication management system, including the home's process and procedures for the destruction and disposal of medication, including narcotics, controlled drugs and substances.

Interviewed registered staff members S#153, S#118, S#119 and S#152 stated to Inspector #117 on April 24 and 25, 2014, that the home's pharmacist and pharmacy assist come approximately once a month to home to review and remove expired /discontinued medications and narcotics from the home.

For medication that are not narcotics, controlled drugs and substances, the pharmacy assistant goes to each resident home area medication room, removes the discontinued / expired medication in clear plastic bins.

For medication that are narcotics, controlled drugs and substances, the pharmacist

reviews with the discontinued/ expired narcotics information with the charge RN, both sign the required documents, and the narcotics are placed in a sharps container. The pharmacist then removes the discontinued/expired narcotics from the home.

All interviewed staff members report that the medications, including narcotics and controlled substances, are not destroyed/ denatured in the presence of a member of the registered staff prior to being removed from the home.

On April 24, 2014, the home's Vice President of Resident Care stated to Inspector #117, that the home's pharmacy provider oversees all aspects of the home's medication management system. She states that she was not aware that the home's medication required to be destroyed/denatured in the presence of a designated registered nursing staff member or Director of Care and she was not aware of the home's current medication destruction/denaturing and disposal process. [s. 136. (3) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home review their policies related to the destruction and disposal processes of all medication, regular and controlled drugs/substances as well as that discontinued and expired medication are destroyed on site in the presence of a designated member of the home's regular nursing staff and the pharmacist, to be implemented voluntarily.***

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**WN #9: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:**
**1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission in that since January 2014 the home has admitted 123 residents and only 6 have been screened for tuberculosis.

During the resident quality inspection Inspector #556 selected six new admissions to the home and reviewed their medical records, none of the six resident's selected had been screened for tuberculosis within 14 days of admission.

A review of the home's Infection Prevention and Control binder was completed including the policy entitled Mantoux PRO-EC23 with a revision date of August 2013 which states "all residents requiring T.B. skin testing must receive a 2 step Mantoux, and all new admissions are tested within one week of admission." Another policy in the Infection Control binder entitled Tuberculosis Surveillance: Residents PRO-N11 with a revision date of October 18, 2013 states a Mantoux tuberculin skin test must be administered within 7 days of admission, and as required.

In an interview registered staff member #S118 stated that in a particular resident care unit none of the fourteen new admissions to that unit have received TB testing. Staff member #S118 further stated that she realizes the Mantoux testing is to be done within the first 14 days following admission.

In an interview the VP of Resident Care stated that out of nine units in the home only one unit has received TB screening for new residents since the move to the new facility in January 2014. [s. 229. (10) 1.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission and if residents had been screened 90 days prior to their admission, that this information be documented in the residents health care records, to be implemented voluntarily.***

**WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 3. (1) (8) as it relates that a resident right to be afforded privacy in treatment and in caring for his or her personal needs was not fully respected and promoted

On April 15, 2014, Inspector #117 observed registered staff member S#121 approach Resident #6 during the lunch time meal service. The resident was seated at his/her dining table, eating his/her meal, in the presence of 3 other table mates. Staff member S#121 proceeded to take a blood sample to assess Resident 36's blood sugar levels. She then prepared the resident's insulin, re-approached the resident, lifted his/her shirt sleeve and administered the insulin while the resident was eating his/her meal.

Staff member S#121 stated to Inspector #117 that she does regularly administer the resident's insulin during his/her lunch time meal, when he/she is seated at the dining room table. She stated that she was not aware of any protocols regarding ensuring the resident's privacy when administering his/her insulin medication. Inspector #117 spoke with Resident #6 who stated that usually registered nursing staff test his/her blood sugars and administer his/her insulin when he/she is in his/her room prior to meals. A review of the resident's health care record was conducted and there are no orders for the resident to receive his/her insulin in the dining room, during meal services.

The unit registered staff member failed to afford Resident #6 privacy when she did blood sugar testing and administered his/her insulin when he/she was eating his/her meal, in the unit dining room. [s. 3. (1) 8.]

**WN #11: 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).**

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**Findings/Faits saillants :**

1. The licensee failed to comply with O.Reg. 79/10, s. 8. (1) in that 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 (b) is complied with. O. Reg. 79/10, s. 8 (1).

Under O.Reg. 79/10, s. 131 (6) the home is required to have a written policy related to residents who can self-administer their own medication. The home does have a policy IX NSG-26.00, revised October 2013 related to SELF- MEDICATION ADMINISTRATION.

The policy states that the resident must sign a consent form for "agreement to participate in the self-medication program" and that pharmacist and Physician need to be notified and do an order. The process also notes that the resident has to be assessed by RPN/RN for 7 days to ensure if he/she is following the correct process to taking and documenting their bedside medications. It also notes that the pharmacy is to provide a special MAR (Medication Administration Record) - printed weekly – for the resident to use at bedside and to document medication taking. After 1 week, nursing staff are to write up an evaluation of the resident ability to self-administer, which is to be reviewed and a decision is then made to see if the resident can continue with self-administration of medication.

On April 22, 2013, during medication management review with registered staff member S#112. The staff member S#112 stated to Inspector #117 that Resident #22 was the only resident allowed to self-administer one of his/her medications. The resident has a medical order, dated on a specific date in April 2014, to self-administer a cardiac medication as needed.

On April 22, 2014, Inspector #117 spoke with the Resident #22 regarding his/her cardiac medication. The resident stated that he/she did have the medication, that it was at his/her bedside but could not give further information related to how and when he/she takes the medication or if he/she was to report taking the medication to the unit RPN. A review of the resident's room was done and it was observed that the resident had two bottles of the cardiac medication at his/her bedside. One with a pharmacy label and medical order, the other without any medical information on it. Also it was noted that there was no MAR to document the resident's medication administration at the bedside.

A review of the resident's health care record was conducted. It was noted that the resident does have some cognitive impairments. No information was found in the chart related to the resident signing an agreement for self-administration of medication. No information was found related to ongoing assessment of the resident's abilities to self-administer the medication. There was documentation in the chart dated on a specific day in February 2014, nursing staff found a non-prescribed bottle of medication at the resident's bedside. This was removed and no further assessment of the resident's abilities to self-administer medication was noted to have been done.

On April 22, 2014, staff member S#112 stated to Inspector #117 that she has not been assessing the resident's abilities to self-administer his/her medication. She states that to her knowledge the resident has not reported any use of the medication and she has not inquired as to the resident taking the medication. She states that the resident is to self report to registered staff when he/she takes the medication. No documentation was found in the resident's MAR or progress notes related to the resident taking his/her medication.

On April 23, 2014, staff member S#109 stated that she was aware that resident had an order for self-administration of the cardiac medication. However, she was not aware that the resident had a 2nd non-prescribed bottle of the medication at his/her bedside. She also stated that she was not aware that the resident's abilities for self-administration of medication were not being assessed. The non-prescribed bottle of medication was removed by staff member S#109 and who then made a note for the physician to review the resident's ability to self-administer his/her medication.

The home did not comply with their own policy for resident self-administration of medication as it relates to the Resident #22, in that there is no signed agreement for

self-administration of medication, there is no MAR at resident bedside, there is no assessment of the resident's abilities to self-administer his/her medication. [s. 8. (1)]

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**WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

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

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**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCHA 2007, S.O., c.8, s.15 (2) (a) in that Resident #555's wheel chair and Resident #556's walker were not kept clean and sanitary.

During a resident quality inspection Resident #555 was observed to be sitting in a wheel chair soiled by patches of white matter in seventeen areas on the back and down the legs of the chair. Also, a walker owned by Resident #556 was observed to be heavily soiled with brown stains on the seat.

In an interview registered staff member #S106 stated that an extra maintenance staff is scheduled on evening shift to deep cleaning resident's equipment. However, if a piece of equipment is lightly soiled then any staff person on the unit is expected to clean it. #S106 further stated that the staff member who assists a resident into bed would then inspect the wheel chair or walker and clean it if it needs to be cleaned so that it is ready for the next morning. Staff member #S106 inspected resident #555's chair and stated that the chair would be considered lightly soiled because it doesn't have an odour, and that it should be cleaned by the PSW staff on the unit.

In an interview front line staff member #S132 stated that when she puts a resident to bed if the wheel chair or walker was lightly soiled she would clean it, and if it was heavily soiled she would send it down to get cleaned. She stated she would not leave

a resident in a dirty chair.

In an interview full time registered staff member #S134 stated it is the personal support worker's responsibility to clean the resident's equipment, and that every time the PSW's take the resident out of the chair they are to wipe down the chair or walker. If the equipment requires a heavier clean it has to be sent downstairs. She further stated the PSW's know that this is their responsibility because an email stating the expectation was distributed and it is in the communication binder on each unit, and it is an expectation that every staff member is to read any new communication. Staff member #S134 inspected Resident #556's walker and stated that it is unacceptably dirty. She further stated that it is at a level of uncleanliness that it should be sent down to have it deep cleaned and that the PSW taking care of that resident on either days or evenings should have filled out a requisition to have the walker cleaned. Staff member #S134 filled out the maintenance requisition on the spot to have the chair cleaned.

In an interview full time front line staff member #S135 stated that it is the PSW's responsibility to wipe down wheelchairs and walkers every evening when residents go to bed and if the equipment is not able to be cleaned with a wipe down then they are to fill out a requisition form and take the equipment down to be cleaned.

A review of the communication binder on a resident care unit indicates that an email was sent to the Registered Staff on February 19, 2014 from the VP of Resident Care stating "the process for PSW's cleaning wheel chairs was they were given disinfectant spray bottles. When removing resident from wheel chair for nap and bed they were to clean out the resident chair with spray and a piece of paper towel. Any visibly soiled chairs were noted and reported to RPN and sent to our maintenance on evening shift to be cleaned." Another email distributed to the Registered Staff on March 13, 2014 from the Coordinator of Clinical Practice & Performance states "please note that deep wheel chair cleaning has commenced in-house. A support staff is available to complete a deep clean on a maximum of 4 wheel chairs per evening."

In an interview the VP of Resident Care stated that if a piece of resident equipment needs to be cleaned ahead of their regular scheduled cleaning then the RPN sends the equipment down to maintenance on evenings to be cleaned. If a deep cleaning is not needed the PSW are to use a spray cleaner and paper towels to clean the equipment. She further stated that this procedure has been communicated to each unit.

In an interview the Manager of Support Services stated that it is the PSW's responsibility to clean lightly soiled wheel chairs and walkers. They are to wipe down the equipment with cleaner as needed. If the equipment is heavily soiled then every evening there is a housekeeper available who can do a deep cleaning on a maximum of four chairs. [s. 15. (2) (a)]

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**WN #13: 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).**

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**Findings/Faits saillants :**

1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, section 24 (1) 2 in that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident has occurred did not immediately report the suspicion and information upon which it is based to the Director.

LTCH Inspector #138 was reviewing the health care record for Resident #16 and came across a progress note dated a specific day in March 2014 indicating that the resident was upset and reported to the RN that an agency staff member used foul language and refused care. The progress note stated that the registered staff immediately went to the agency staff member and escorted the agency staff member out of the building. A following progress note stated the resident's substitute decision maker was made aware of the incident.

LTCH Inspector #138 reviewed the MOHLTC's Critical Incident System (CIS). The CIS is the primary communication tool of the homes to the Director and is used by the homes to communicate any suspected incidents of resident abuse or neglect. The LTCH Inspector was not able to locate any submission in the CIS from the home outlining the incident on the identified day in March 2014. LTCH Inspector #138 spoke with the VP Resident Care who stated that the home should have sent information regarding the incident through the CIS however the information had not been sent. Thus, the Director had not been made aware of an incident suspected resident abuse and neglect that occurred with Resident #17 on the identified day in March 2014. [s. 24. (1)]

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**WN #14: 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. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,**
**(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).**
**(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).**

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**Findings/Faits saillants :**

1. The licensee failed to comply with O. Reg 79/10 section 26 (4) (a) in that the licensee failed to ensure that a registered dietitian who is a member of the staff of the home completes a nutritional assessment for all residents on admission.

LTCH Inspector #138 was reviewing Resident #6's health care record on April 24, 2014 as part of a mandatory task related to the Resident Quality Inspection process. According to the health care record, Resident #6 was admitted to the home on an identified day in March 2014 with a diagnosis of diabetes with poor control and kidney disease requiring active treatment. The admitting physician's diet order, made the same day as the resident's admission, was modified diabetic/renal diet and was further updated the 3 days after admission to a modified diabetic/renal diet with a regular texture. Further review of the health care record demonstrated that the home's registered dietitian entered a progress note the two days after the resident's admission in March 2014 indicating that she visited the resident at lunch, that she would continue to monitor the resident, and that she would complete the initial nutrition assessment around fourteen days of admission. A second progress note was made by the registered dietitian 5 days later (7 days post-admission) indicating that she was continuing to monitor the resident prior to completing the initial assessment. The initial MDS (Minimum Data Set) and RAPs (Resident Assessment Protocols) were reviewed and it was noted by the LTCH Inspector that the Nutritional Status was triggered as a RAP but had not been completed.

LTCH Inspector #138 spoke with the home's registered dietitian on April 25, 2014 regarding the process for completing the initial nutrition assessment. The registered dietitian stated that the initial nutrition assessment is to be completed within fourteen days of admission and is concluded when the RAPs are completed. She also stated that she will enter a progress note indicating that the initial nutrition assessment has been completed. With respect to Resident #6, the registered dietitian stated that the she had been late in completing the resident's initial nutrition assessment and that it had not been completed upon admission.

LTCH Inspector #138 reviewed Resident #6's health care record again on April 28, 2014 and noted a progress note by the registered dietitian dated April 24, 2014 stating that the initial nutrition assessment had been completed. The LTCH Inspector reviewed the RAPs once again and noted that the RAP for Nutritional Status was now complete.

The initial nutrition assessment was completed thirty six days after admission. [s. 26.

(4) (a),s. 26. (4) (b)]

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**WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

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**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg 79/10, s.30 (2), whereby the licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Resident #640 has a physician order for special dressing change for stage 4 ulcer twice a week/ as needed for the month of February 2014 and March 2014. Upon reviewing the resident #640 treatment sheets, for a period of 13 consecutive days in March 2014, no documentation were recorded with regards to dressing change in the treatment sheet or in the e-notes of point click care.

On April 23, 2014 registered staff member S#118 assigned for Skin and wound Care confirmed during an interview with Inspector #573 that there is no documentation recorded with regards to dressing change in the treatment sheet for that identified 13 day period in March 2014 and further stated that as per nursing documentation standards if there is no documentation recorded in the treatment chart it is assumed that treatment is not provided. [s. 30. (2)]

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**WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

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

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**Findings/Faits saillants :**

1. The licensee failed to comply with the O. Reg 79/10, s.50 (2)(b)(i), whereby the licensee did not ensure that Resident #640 received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

The home's policy "Skin and Wound Care Program" #R50 was reviewed by Inspector 573. In the procedure for the residents with pressure ulcers the policy states that "upon discovery of a pressure ulcer, registered staff will initiate a baseline assessment using a clinically appropriate assessment instrument (i.e. .Form N-161 Pressure Ulcer /Wound Assessment Record) from the Registered Nurses Association of Ontario (RNAO) Toronto Best Practice Implementation Steering Committee". the policy further states that "After a dressing change, complete the pressure Ulcer/Wound Assessment Record (weekly) including size (Circumference and Depth) of the wound ,discharge from the wound, appearance, progression ,pain ,nutrition ,equipment being used etc."

Nursing documentation in Point Click Care progress notes on a specific day in April 2014, confirmed that resident #640 has a stage X – wound and since then according to the nursing documentation in the progress notes it indicates that the wound is been treated with special dressing as of today.

The health care record was reviewed by Inspector #573, and there was no documentation to support that a Form N-161 Pressure Ulcer /Wound Assessment Record had been completed for this resident and there was no documentation to support that after a dressing change a pressure Ulcer/wound Assessment Record (weekly) assessments were completed that included the size, appearance, progression, pain and condition of skin for the current pressure ulcer, as per the home's policy.

Registered staff member S#118 assigned for Skin and wound Care confirmed on April 23, 2014 that Form N-161 Pressure Ulcer /Wound Assessment Record for resident #640 was not completed and/or documented for either Resident #640s two identified wounds, as per the home's policy.

On April 25, 2014 V.P. Resident Care stated that Registered Nursing Staff must complete a Form N-161 Pressure Ulcer /Wound Assessment Record for every resident with stage 3, 4 and Unstageable Wounds. [s. 50. (2) (b) (i)]

**WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to comply with O. Reg 79/10 section 71. (4) in that the licensee failed to ensure that the planned menu items are offered and available at each meal and snack.

LTCH Inspector #138 observed the breakfast meal service on Waterford House on April 23, 2014. It was noted by the LTCH Inspector that the pureed muffin indicated on the menu was not available to residents on a pureed diet. It was confirmed by the nutritional service aide, Staff #145, that pureed muffin was not available.

LTCH Inspector #138 observed the lunch meal service on Cavan House on April 23, 2014. The LTCH Inspector was approached by a family member of a resident in the dining room towards the end of the lunch meal and requested that bread be provided to the residents with their meals. The LTCH Inspector reviewed the home's menu for lunch and noted that rolls, sliced bread, and pureed bread were a part of the lunch menu. It was observed by the LTCH Inspector that rolls, sliced bread, and pureed bread were not offered or provided to residents at any time throughout the lunch meal service.

LTCH Inspector #138 observed another breakfast meal service on Wexford House on April 25, 2014 and noted that pureed sausage was not available as per the home's menu. This was confirmed by the nutritional service aide, Staff #144. [s. 71. (4)]

**WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, section 76 (2) 3 in that the licensee failed to ensure that no person performs their responsibilities before receiving training in the long term care home's policy to promote zero tolerance of abuse and neglect of residents.

After inspecting an incident of resident abuse involving an agency staff member, LTCH Inspector #138 spoke with the Manager of Resident and Family Services on April 25, 2014 who coordinates the resident abuse training program for the home. The Manager of Resident and Family Services stated that he has organized abuse training for all staff in the home but further stated that agency staff is not included in the home's abuse training program. In accordance with LTCHA 2007 section 74 (2) and 75 (3), agency staff is considered staff of the home and considered to be hired when he or she first works at the home.

Further discussion was held with the Human Resources Manager on April 28, 2014 who stated that she used to coordinate the training requirements including abuse training for all new staff but that this process changed in late 2013 whereby each department is responsible to ensure that their new staff members receive the required training, including abuse training, prior to starting their shifts.

Discussion was held with the VP Resident Care on April 29, 2014 regarding abuse training that is provided to agency staff prior to starting work in the home. The VP Resident Care stated that the home's abuse policy used to be posted in the old building and that agency staff could reference the posted policy if required but that specific abuse training was not provided by the home. It was also noted as per LTCHA 2007 section 79 (3) (c) that the home's abuse policy is not posted at the time of this inspection. The VP Resident Care did state that the organization who provides the home with agency staff does abuse training with the agency staff before being deployed to the home.

LTCH Inspector spoke with the Executive Director of the organization who provides agency staff to the home. The Executive Director outlined the process in which staff are hired, trained and retrained. The Executive Director stated that abuse training is provided to the agency staff is based on the legislative requirements but did state that the home's specific abuse policy is not included in the abuse training. [s. 76. (2) 3.]

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**WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information**

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c. 8 , s. 79 (3) in that the following information was not posted as per legislative requirements (a) the Residents' Bill of Rights; (c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; (d) an explanation of the duty under section 24 to make mandatory reports; (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; (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; (n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; (o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; (p) an explanation of the protections afforded under section 26.

On April 14, 15, 16 and 17, 2014, it was noted by Inspectors #117 and #573 that the following information was not posted in the home:
• Resident's Bill of Rights
• an explanation of the duty under section 24 to make mandatory reports;
• 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;
• the home's policy to promote zero tolerance of abuse and neglect of residents
• the home's policy to minimize restraints,
• the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council
• the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council
• an explanation of the protections afforded under section 26; (whistleblowing)

On April 16 and 17, 2014, the home's Vice President of Building Operations and Vice President of Resident Care stated to Inspector #117 that home has not posted the above information. They stated that the home's plan is to have the above information posted on an electronic TV screen by the home's elevators. This TV screen has not been installed. Installation time lines are undetermined as the home is waiting the more information from their contracted IT service provider, therefore the information has not been posted.

The Vice President of Building Operations also stated that on April 16, 2014, the home had just received 55 new bulletin boards. These are to be distributed and mounted in all of the home's 9 resident home areas in May 2014. The bulletin boards are to be used to post information for resident and families including minutes of the Resident and Family Councils.

The home has not posted any of the above required information since their move into their new building on December 31, 2013. [s. 79. (3) (a)]

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**WN #20: 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. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).**

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**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 85 (1) in that the licensee did not ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

On April 22, 2014 Inspector #573 spoke with the President and CEO who indicated that the home has not conducted a survey of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home for 2013. [s. 85. (1)]

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**WN #21: 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. (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):**
**4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

1. The licensee failed to comply with O.Reg. 79/10, s. 107 (3) (4) in that the Director was not informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): An incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Resident #21 was admitted to the home on a specific day in February 2014. Chart documentation indicates that at the time of admission, the resident's family member informed the Admissions Coordinator S#152 that the resident is to have his/her wheelchair lap belt applied at all times as the resident is at high risk for falls. The family member reported that Resident #21 had sustained a fall with injuries two days prior to his/her admission. On the day of admission, the attending physician wrote an order for a wheelchair lap belt to be applied for safety when resident is up in wheelchair.

Four days after being admitted, Resident #21 fell out of his/her wheelchair. Chart documentation indicates that the wheelchair lap belt had not been applied. Unit RPN assessed the resident. No injuries were noted at that time and the resident was placed on post-fall head injury protocol for increased monitoring.

Approximately 10 hours later, Resident #21 was assessed as per post-fall head injury protocol and found to have changes in his/her health status. The resident's family member was contacted and the resident was transferred to hospital for further assessment. Chart documentation indicates that the resident was admitted to hospital and that the resident's family member discharged Resident #21 from the home that same day.

On April 25, 2014, staff member S#152 reports that no critical incident report was sent to the Director as the resident was discharged from the home the same day that

he/she was transferred and admitted to the hospital. Inspector #117 reviewed the MOHLTC's Critical Incident System (CIS). The CIS is the primary communication tool of the homes to the Director and is used by the homes to report critical incidents as per legislated requirements. The Inspector was not able to locate any submission in the CIS from the home outlining the incident related to Resident #21's change in condition, transfer and admission to hospital.

The home did not report Resident #21's change in condition, transfer and admission to hospital to the Director as required under the legislation. (log #O-000215-14) [s. 107. (3) 4.]

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**WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device**

**Specifically failed to comply with the following:**

**s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:**
**1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).**

**s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:**
**6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).**

**s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:**
**5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).**

**s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:**
**6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).**

**s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:**
**7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).**

**s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:**
**8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).**

**s. 110. (8) Every licensee shall ensure that every use of a physical device to restrain a resident pursuant to the common law duty referred to in section 36 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:**
**5. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (8).**

**Findings/Faits saillants :**

1. The licensee failed to comply with O. Reg 79/10 section 110 (1) 1 in that the licensee failed, with respect to the restraining of a resident by a physical device under section 31 of the Act, to ensure that staff apply the physical device in accordance with any manufacture's instruction.

On April 23, 2014 Inspector #556 observed Resident #740 sitting in a wheel chair in the dining room with a seat belt applied six inches too loose.

A review of the resident's medical record indicates there is a physician's order dated June 9, 2013 for wheel chair with safety belt with a ten pound clasp.

A review of the homes policy entitled Restraints: Use of Least Restraints Part II-L29

with a revision date of October 15, 2011 states Care Plan is to outline specific steps for applying and reapplying the device according to instructions given in the order and to manufacturer's instructions and specifications; specify instructions in the care plan.

A review of the resident's care plan indicates that physical restraint use is included in the resident's care plan however there is no indication of how the restraint device is to be applied.

Staff member #S130 who gave morning care to Resident #740 on April 23, 2014 stated that the seat belt was about five or six inches too loose but the seat belt was stuck and could not be tightened. Staff member #S130 further stated Resident #740 doesn't move, and while it's not good for the seat belt to be loose like that, the resident stays put and is therefore not at risk. She stated that the seat belt does need to be applied because it is part of the resident's care plan.

Registered staff member #S120 observed the seat belt on the resident and stated that there should only be room to put a flat hand between the resident and the seat belt and proceeded to tighten the seat belt on Resident #740 while Inspector #556 was present. Registered staff member #S120 further stated that the seat belt had not been applied correctly. [s. 110. (1) 1.]

2. On April 15, 2014 Inspector #573 observed Resident #620 sitting in a Broda wheel chair with a lap belt that was not positioned across the hips and had more than approximately 7 inches between the belt and pelvic crest.

On April 16, 2014 Inspector #573 observed Resident #615 sitting in a wheel chair with a 4 point lap belt the outer one strap is not secured properly, the lap belt was also observed to be loose as evidenced by a greater than 10 inches between the belt and pelvic crest. [s. 110. (1) 1.]

3. On April 29, 2014 the Licensee contracted occupational therapist confirmed during an interview with Inspector #573 that the wheel chair seat belt has to be applied properly. Definitely not too tight or loose, there should be a finger width space between the belt and the hips, the seat belt has to be snug fit so that it prevents residents sliding out from the wheel chair. [s. 110. (1) 1.]

4. On April 22, 2014, LTCH Inspector #138 observed Resident #3 seated in a wheelchair with a lap belt applied loosely over the resident's hips. The LTCH Inspector

noted that the lap belt could be pulled four to six inches away from the resident's body. LTCH Inspector #138 spoke with the unit RPN, Staff #104, who examined the resident's lap belt and agreed that it was too loose. Staff #104 worked with Staff #102 to readjust the resident's lap belt so that it properly fit the resident.

On April 24, 2014, LTCH Inspector #138 was observing a breakfast meal service and observed that Resident #17 was in a wheelchair with a lap belt applied very loosely around the hips. Upon further observation, the LTCH Inspector noted that the lap belt could be pulled six to seven inches away from the resident's body. LTCH Inspector #138 spoke with the unit RPN, Staff #15, who examined Resident #17's lap belt and stated that she agreed that it was too loose. Staff #17 stated that she would call to have someone come and adjust the lap belt to fit the resident properly. LTCH Inspector #138 followed up the next day and noted that the resident's lap belt was properly fitting. [s. 110. (1) 1.]

5. The licensee failed to comply with O.Reg 79/10, s.110 (2) (6) in that the resident's condition was not reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

Resident #555 has advanced dementia, is identified as being at high fall risk and has a lap belt front buckle restraint as a fall prevention intervention.

A review of the resident's health care record was conducted by Inspector #117. It was noted that the resident's current plan of care identifies that the resident has a lap belt restraint. However no documentation was found related to the monitoring of the application, the repositioning and the removal of the resident's lap belt restraint. Also no information related to the assessment of the resident's condition and the effectiveness of the restraining was noted to be evaluated by a member of the registered nursing staff, at least every eight hour.

Staff member RPN S#106, reviewed the resident's health care record with Inspector #117 on April 22, 2014. She stated to that she was not aware of any process for registered nursing staff to monitor resident's condition when a restraint is applied. Also, RPN S#106 stated that she could not find any documentation in the resident's record indicating that when staff apply the resident's lap belt, when the resident is being repositioned and the lap belt removed. [s. 110. (2) 6.]

6. The licensee failed to comply with O. Reg 79/10 section 110. (7) (5, 6, 7 and 8) in that the licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented.

Resident #555 has advanced dementia, is identified as being at high fall risk and has a lap belt front buckle restraint as a fall prevention intervention.

A review of the resident's health care record was conducted by Inspector #117. It was noted that the resident's current plan of care identifies that the resident has a lap belt restraint. However, no documentation was found related to the application of the lap belt restraint; the assessment, reassessment and monitoring, including the resident's response; the release of the device and all repositioning; as well as the removal of the resident's lap belt restraint.

Staff member RPN S#106, reviewed the resident's health care record with Inspector #117 on April 22, 2014. Restraint initiation/monitoring/documentation flow sheets were found for the months of January, February and March 2014. The March 2014, flow sheet indicates that on 15/31 day shifts and on 6/31 evening shifts there is no documentation related to the application / monitoring / repositioning and removal of Resident #555's lap belt.

No information was found related to the application / monitoring / repositioning and removal of Resident #555's lap belt for the month of April 2014. The RPN S#106 stated that she could not find any documentation in the resident's record indicating that nursing staff were currently documenting the application / monitoring / repositioning and removal of Resident #555's lap belt.

Resident #21 was admitted for short stay respite on February 28, 2014. It is noted that the resident had previously been admitted to the home in late November 2013. At the time of the resident's admission, the resident's son informed the home's Admission Coordinator RPN S#152 that the resident had sustained several falls in the past few weeks, including a fall, with bruising injuries, that had occurred two days prior to Resident #21's respite admission. The resident's family member also informed the home's Admission Coordinator that when the resident is seated in his/her wheelchair, the wheelchair lap belt restraint needs to be applied at all times due to the resident risk for falls. This information was given to Inspector #117 by the resident's family

member on April 23, 2014 and confirmed that same day with the Admissions Coordinator RPN S#152. Progress notes document that on March 4, 2014, Resident #21 fell out of his/her wheelchair as the lap belt had not been applied

A review of Resident #21's health care record was conducted in the presence of RPN S#152 on October 24, 2014. No plan of care and no Restraint Initiation / Monitoring / Repositioning record was found in the resident's chart. On April 24, 2014, staff members PSWs S#149 and S#150 stated to Inspector #117 that they did provide care to Resident #21 during his/her stay at the home. However, there is no documentation found in the resident's chart related to the application, monitoring, repositioning and removal of the resident's lap belt. (log #O-000215-14) [s. 110. (7) 5.]

7. The licensee failed to comply with O. Reg 79/10 section 110. (7) (5 and 7) in that the licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented.

LTCH Inspector #138 reviewed the health care record for Resident #2 and Resident #4 after observing that both residents had not been released from their restraints and repositioned in accordance with O. Reg 79/10 s. 110, (2) 4 on April 22, 2014. The current care plan for Resident #2 stated that the resident was to be in a tilt wheelchair with a lap belt and a table top on the wheelchair as a physical restraint and the current care plan for Resident #4 stated that the resident was to wear a lap belt as a physical restraint.

A PSW, Staff #102, stated to LTCH Inspector #138 that the documentation of all restraints was completed by the PSW's on the Restraint Monitoring Record found in the flow sheet binder for the residents. The LTCH Inspector reviewed the flow sheet binder and observed for Resident #2 that the Restraint Monitoring Record was not consistently completed in that twenty five of the forty two required entries for April 1 -21, 2014 regarding restraint use were left blank. The LTCH Inspector was unable to locate a Restraint Monitoring Record for Resident #4.

On April 24, 2014, LTCH Inspector #138 observed during a meal observation that a lap belt applied to Resident #17 was not applied in accordance with O. Reg 79/10 section 110 (1) 1. The LTCH Inspector reviewed the resident's health care record and noted that the resident is planned to wear a physical restraint.

LTCH Inspector #138 spoke with RN, Staff #122, regarding the documentation of

application and release of restraints. Staff #122 stated that the documentation is completed by the PSW's on the Restraining Monitoring Record but stated that this documentation is a current challenge for the home and acknowledged that it is not consistently completed and that the Restraining Monitoring Record may not even be able for documentation. [s. 110. (7) 5.]

8. The licensee has failed to comply with O.Reg. 79/10, s. 110 (8) (5) in that the release and repositioning of Resident #740 from a physical device was not documented on ten separate shifts in April 2014 no documentation was completed.

A physician's order dated June 9, 2013 indicates Resident #740 is to have a safety belt with a ten pound clasp applied when resident is up in wheel chair.

A review of Resident #740's care plan indicates that staff are to check resident and release restraint as per facility protocol.

A review of the homes policy entitled Restraints: Use of Least Restraints Part II-L29 with a revision date of October 15, 2011 states the interdisciplinary team is to document every hour on the restraint monitoring record and every two hours when the restraint is released and the resident is repositioned.

A review of the Restraint Monitoring Record for April 2014 on Resident #740's medical record indicates that on the day shift on April 1, 2, 3, 4, 18, and 22, and the evening shift on April 6, 11, 14, 15, there was no documentation to indicate that Resident #740 had been released and repositioned at least once every two hours, however progress notes on each of those days indicate that the resident was present in the home.

Additional Required Actions:

CO # - 002 will be served on the licensee under LTCHA. s. 31 (1). Refer to "Order(s) of the Inspector". [s. 110. (8) 5.]

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**WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD**

**Specifically failed to comply with the following:**

**s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,**
**(a) is well maintained; O. Reg. 79/10, s. 111. (2).**
**(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).**
**(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).**

**Findings/Faits saillants :**

1. The licensee failed to comply with O. Reg 79/10 section 111 (2) (b) in that the licensee failed to ensure that a PASD is applied by staff in accordance with any manufacturer's instruction.

On April 22, 2014, LTCH Inspector #138 observed Resident #1 seated in a wheelchair with a lap belt applied loosely over the resident's hips. The LTCH Inspector noted that the lap belt could be pulled six to eight inches away from the resident's body. LTCH Inspector #138 spoke with staff member S#104, who examined the resident's lap belt and agreed that it was too loose and adjusted the lap belt to fit properly.

LTCH Inspector #573 spoke with the home's occupational therapist on April 29, 2014 regarding the proper application of lap belts. The occupational therapist stated to the LTCH Inspector that lap belts are to be applied snug to the residents' hips. [s. 111. (2) (a),s. 111. (2) (b),s. 111. (2) (c)]

**WN #24: 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 failed to comply with O. Reg. 79/10 s.129. (1) (a)(ii) in that all drugs are stored in an area or a medication cart that is secure and locked.

On April 15, 2014 at 13:58, on a secured unit in 3rd floor, in Room 308 within a shared bathroom Inspector #573 observed a medicated ointment in a resident's unlocked drawer.

An interview with the registered staff member S#127 and staff member S#128 on 3th floor secured unit confirmed with the Inspector that the medicated ointment is to be kept locked at all times. [s. 129. (1) (a) (ii)]

**WN #25: 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 failed to comply with O.Reg. 79/10 s. 130 (2) in that all areas where drugs are stored are restricted to person who may dispense, prescribe or administer drugs in the home, and the Administrator.

On April 23 and 24, 2014, a review of the home's medication storage areas and the security of drug supplies were conducted by Inspector #117.

On April 23, 2014 Inspector #117 toured the home's medical supply room and government stock medication supply storage cupboard with the home's Vice President of Building Operations. Two (2) carts were seen in the room that had on them several medication: 10 bottles of acetaminophen 325 and 500 mg, 2 bottles of Milk of Magnesium, 3 bottles of Potasium Chlohide, 20 bottles of Vitamin B 12, a case of Isopto tears, 1 bottle of Mucillium.

The Vice President of Building Operations informed Inspector #117 that up until the week of April 14, 2014 the home's government stock medication was stored in an open area of the medical supply room. He stated that he, the home's two ward clerks and the Vice President of Clinical Care all have access to the medical supply room. (location of observed carts). As of April 14, the government stock medication was placed in a locked cabinet and that the ward clerks and Vice President of Clinical Care have the keys to the medication cabinet.

April 23, 2014, the home's Vice President of Resident Care confirmed that the home's

government stock medication had been stored in an open area of the medical supply room up until the week of April 14, 2014, when the home received a secure cabinet in which to store the medication. She confirmed that home's Vice President of Building Operations, the two ward clerks and the Vice President of Clinical Care do have access to the medical supply room. She also stated that the two ward clerks and the Vice President of Clinical Care do have access to the new secure medication cabinet.

On April 24, 2014, Inspector #117 spoke with ward clerk S#117 who confirmed that she does have a key to access to the secure medication cabinet in the medical supply room. She stated that she has had a key to access and deliver government medication to unit medication rooms for the past 3 years. She stated that she is not a member of registered nursing staff and is not allowed to dispense, prescribe or administer drugs in the home, nor is the other ward clerk.

Neither the nursing ward clerks or the Support Services Manager are allowed to dispense, prescribe or administer drugs in the home, and therefore should not have access to secured medication storage areas and cupboards. [s. 130. 2.]

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**THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/**
**LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:**

| COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS: | | | |
|---|---|---|---|
| **REQUIREMENT/ EXIGENCE** | **TYPE OF ACTION/ GENRE DE MESURE** | **INSPECTION # / NO DE L'INSPECTION** | **INSPECTOR ID #/ NO DE L'INSPECTEUR** |
| LTCHA, 2007 S.O. 2007, c.8 s. 3. (1) | CO #001 | 2011_042148_0019 | 117 |
| O.Reg 79/10 s. 71. (3) | CO #001 | 2014_128138_0011 | 138 |

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**

**Issued on this 4th day of June, 2014**

| Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs |
| --- |
| Lyne Duchesne RN #117 Paula MacDonald #138 RD<br>ANDY NATARAJAN PT #573<br>Wendy Patterson RN #556 |

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

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

**Public Copy/Copie du public**

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| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | LYNE DUCHESNE (117), ANANDRAJ NATARAJAN (573), PAULA MACDONALD (138), WENDY PATTERSON (556) |
| **Inspection No. / No de l'inspection :** | 2014_198117_0011 |
| **Log No. / Registre no:** | O-000302-14 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | May 9, 2014 |
| **Licensee / Titulaire de permis :** | ST. PATRICK'S HOME OF OTTAWA INC.<br>2865 Riverside Dr., OTTAWA, ON, K1V-8N5 |
| **LTC Home / Foyer de SLD :** | ST PATRICK'S HOME<br>2865 RIVERSIDE DRIVE, OTTAWA, ON, K1V-8N5 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | LINDA CHAPLIN |

To ST. PATRICK'S HOME OF OTTAWA INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,

(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and

(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that there is an organized program of personal support services on Waterford House and Wexford House to meet the assessed needs for those residents for morning care.

This plan must be submitted in writing to Paula MacDonald and Lyne Duchesne, LTCH Inspectors at 347 Preston St, 4th floor, Ottawa, ON, K1S 3J4 or by fax (613) 569-9670 on or before May 16, 2014.

While this plan is being prepared, the licensee must ensure the following:

- Residents on Waterford House and Wexford House must be in the dining room before the end of the schedule breakfast meal service (09:30am), unless otherwise specified in the residents' plan of care.

- The home shall ensure that adequate staff are in the dining room for the scheduled breakfast meal service (08:00 to 09:30am) to serve, assist and supervise residents with their breakfast.

- All residents on Waterford House and Wexford House are to be served their entire breakfast prior to the end of the scheduled meal service (09:30 am), unless otherwise specified in the residents' plan of care.

- Mid-morning beverages shall be offered to all residents on Waterford House and Wexford House according to the home's snack menu.

- Residents wearing physical devices for the purpose of restraining or PASDs on Waterford House and Wexford House are to be released from the devices and repositioned at least every 2 hours or as required by the legislation. This is to be implemented immediately.

**Grounds / Motifs :**

1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, section 8 (1) (b) in that the licensee failed to ensure that there is an organized program of personal support services for the home to meet the needs of the residents on Waterford House and Wexford House.

LTCH Inspector #138 was on Waterford House, a 32 bed unit on the fifth floor, the mornings of April 22 and 23, 2014 and on Wexford House, another 32 bed

unit on the fifth floor, on April 24 and 25, 2014. The LTCH Inspector established that the breakfast meal service on both units is scheduled to begin at 8:00am and is scheduled to finish at 9:30am when the nutritional service aide for each unit is required to remove the bulk of the hot breakfast menu items from the dining room and return to the main kitchen. It was also established that the RPNs for both units will provide assistance to residents in the dining room when able but that the RPNs are also assigned to the residents' medication pass and can only provide intermittent assistance to residents with their meals.

It was further established on Waterford House that the unit recreologist is planned to assist residents in the dining room from 8:00am until 8:45am after which a PSW is to join the dining room and continue to provide assistance to residents. It was noted by LTCH Inspector #138 on April 22 and 23, 2014 on Waterford House that the recrealogist and her student were available in the dining room assisting residents, however, it was noted that a PSW did not come to the dining room at 8:45am both mornings as was planned. Once the recreaologist and her student left the dining room the RPN was the only staff member present to assist the residents with their meals (the nutritional service worker was present until 9:30am but was busy with food production and service duties). It was noted that the RPN was not solely dedicated to the dining room at this time as she had medication administration duties to complete. It was also noted by the LTCH Inspector on both days on Waterford House that several residents were brought to the dining room after the planned finish time for the breakfast meal (9:30am) and, as a result, hot food menu items such as eggs, hot cereal, and fortified cereal were not available to those residents as these items had been taken away. It was also observed by the LTCH Inspector that the PSWs were not present in the Waterford dining room until approximately 9:45am both mornings. This is fifteen minutes after the scheduled completion of the meal service. It was also noted by the LTCH Inspector that the PSWs in the dining room at 9:45am were busy assembling breakfast meals and making toast since the nutritional service aide was gone. This meal assembling task competed with the PSWs ability to assist the residents with their meals.

On Wexford House, on April 23 and April 24, 2014 the LTCH Inspector observed that the PSW's were not in the dining room until approximately 9:45am both days. This, again, is fifteen minutes after the breakfast meal is scheduled to be completed and after the bulk of the hot foods menu items are removed from the unit. Once the PSWs arrived in the dining room at 9:45am, meal assembly became their primary duty as the nutritional service aide was no longer on the

unit. The duty of assembling meals and making toast competed with the PSWs time to provide assistance to residents in the dining room. It was noted by the LTCH Inspector that several residents were brought to the dining room after the scheduled completion of the breakfast meal service (9:30am). The last resident was brought into the dining room at 10:15 am.

It should be noted that lunch on both Waterford House and Wexford House is at 12:00 pm and for many residents this is approximately two hours after the breakfast meal. The home has not provided adequate time between the breakfast and the lunch meal to ensure a healthy appetite to promote increased intake at the lunch meal for these residents.

The following resident specific observations were made by LTCH Inspector #138 at breakfast the mornings of April 22 and 23, 2014 on Waterford House:

Resident #5
April 22, 2014 - Resident #5 was brought into the dining room at 9:26 am and provided hot cereal several minutes later. The resident was then almost immediately provided the next course of breakfast of eggs and toast before having adequate time to finish his/her hot cereal. O.Reg 79/10 section 73 (1) 8 states that residents shall be offered course by course service of meals. The eggs and toast were provided to the resident as the hot food was being taken away from the dining room.
April 23, 2014 – Resident #5 finished the cereal portion of the meal at 9:38am and was not provided the next course until almost twenty minutes later. The resident was not offered a choice and instead was provided a muffin and one boiled egg. The plan of care for the resident stated that the resident is to be provided a double egg portions at breakfast. No additional egg was offered to the resident. In addition, there was no indication in the plan of care that the resident is a late riser in the morning.

Resident #19
April 22, 2014 – Resident #19 was brought into the dining room at 9:35am, after the scheduled end of the meal service, by staff and was provided only toast and orange juice. The resident was not offered any choice from the menu including eggs as they were no longer available.
April 23, 2014 – Resident #19 was brought into to the dining room at 9:36am by staff. Staff were overheard discussing the resident's preference for breakfast and the RPN stated that it was oatmeal. No oatmeal was available as it had

been removed at 9:30am so staff provided the resident with cold cereal instead. Toast was later provided to the resident but there were no eggs available to be offered to the resident.
The resident's plan of care was reviewed and there was no indication that the resident has a preference to be a late riser.

Resident #16
April 22, 2014 – Resident #16 came to the dining room at 9:40am and was provided cold cereal and toast. The resident was not offered a choice of hot cereal or eggs as neither were available any longer. The resident voiced frustration to the LTCH Inspector stating that he/she wishes to be up earlier in the morning as he/she suffers leg cramps if in bed too long. The resident further stated that he/she is dependent on staff to get him/her up and has to wait until staff are ready to assist him/her which can be late in the morning. The LTCH Inspector reviewed the resident's plan of care and there was no indication that the resident was to be a late riser. The LTCH Inspector reviewed the progress notes on the resident's health care record and viewed entries that outlined complaints from the resident regarding leg pain early in the morning.

Resident #20
April 23, 2014 – Resident #20 was brought into the dining room by staff at 9:41am. The resident was not offered eggs or hot cereal as both were no longer available. The resident's plan of care did not outline that the resident is a late riser.
April 24, 2014 – Resident #20 was already in the dining room at 9:20am when the LTCH Inspector arrived. The resident was exhibiting difficulty eating scrambled eggs and was observed to struggle to attempt to fed self the eggs for the next fifteen minutes when the resident was observed to drop his/her spoon and eat the eggs with his/her fingers. The resident continued to attempt to fed self with his/her fingers for another fifteen minutes when the resident was cleaned up by staff. No feeding assistance had been provided by staff. The resident's plan of care stated that the resident required set up and supervision while eating.

Resident #24
April 22, 2014 – Resident #24 was brought into the dining room by staff at 9:45am and provided cold cereal and toast. The resident was not offered a choice of foods as hot cereal and eggs were no longer available. It was observed by the LTCH Inspector on both April 22 and April 23, 2014 that there

was a small container on the counter in the dining room labelled protein powder for the resident with instructions to put in the resident's hot cereal. The protein powder was not provided to the resident both days. The electronic plan of care was reviewed for the resident and it stated that the resident is to be provided 6 g (1 scoop) protein powder three times daily at meals; in oatmeal at breakfast, in soup at lunch, in fruit juice at supper. In addition, the plan of care did not indicate that the resident is a late riser.

Resident #25
April 22, 2014 – Resident #25 was brought into the dining room by staff at 9:45am. The resident was not offered a choice of foods and was provided cold cereal and toast. No egg was available. The resident's plan of care did not outline that the resident is a late riser.

Resident #26
April 23, 2014 – Resident #26 was in the dining room eating breakfast at 9:38am and was overheard by the LTCH Inspector to ask for water at 9:48am stating that the resident found the air dry. The resident further stated that there was no water at the table. The LTCH Inspector noted that the resident did not have any beverages to drink. The resident again asked for water several minutes later when a PSW was in the resident's vicinity but nothing was provided. At 9:55am the resident was being removed from the dining room by the RPN. The LTCH Inspector intervened and directed the RPN to provide the resident a beverage as the LTCH Inspector had already determined from the previous day that not all residents are not offered a mid-morning beverage.

Resident #27
April 23, 2014 – Resident #27 was brought to the dining room at 10:02am by staff and provided apple juice and water, cold cereal and milk. No milk as a beverage was provided to the resident as instructed by the resident's plan of care. The LTCH Inspector spoke with the resident on April 25, 2014 and the resident stated that he/ she prefers to get up early in the morning as he/she had always been an early riser. The resident stated that he/she is unable to get up him/herself up and must wait for staff to come get him/her. The LTCH Inspector spoke with a PSW on the unit, Staff #124, who stated that the resident is awake in bed when staff go to get the resident up at 8:50 am and is usually voicing that he/she is hungry.

The following resident specific observations were made by LTCH Inspector #138 at breakfast the mornings of April 24 and 25, 2014 on Wexford House:

Resident #11
April 24, 2014 – Resident #11 was observed with a bowl of cereal, sitting at the dining room table at 8:37am. The resident was not eating and had his/her eyes closed. Verbal encouragement to eat was provided to the resident at 8:48am but was not effective. At 9:10am, the resident was still not eating and no assistance was provided. The weight record was reviewed and it was observed that the resident has a recent history of undesirable weight loss.

Resident #12
April 24, 2014 – LTCH Inspector overheard Resident #12 express frustration to tablemates at 9:37am about the lack of service in the dining room. Resident 312 further stated that he/she had finished his/her cereal and wanted the rest of his/her breakfast. At 9:45am, the RPN took the resident's order for eggs and toast. Toast only was provided to the resident at 9:58am as the eggs were no longer available. The LTCH Inspector spoke with Resident #12 who stated that he/she was frustrated with morning care because he/she is dependent on staff to get up in the morning and if staff were late in getting him/her up from bed than he/she could not get to the dining room before the hot food was gone.

Resident #13
April 24, 2014 – Resident #13 was assisted to the dining room table at 9:35am and was not offered anything to eat until fifteen minutes later when the resident was provide cold cereal followed by toast. The resident was not offered any choice and no eggs were available. The resident's plan of care did not indicate that the resident was a late riser.

Resident #14
April 24, 2014 – Resident #15 was assisted to the dining room at 9:45am. The resident was offered hot cereal but there was none in the dining room and instead was provided cold cereal and toast. Again no eggs were available. The resident's plan of care did not indicate that the resident was a late riser.

Resident #10
April 24, 2014 - Resident #10 was observed in the dining and finished his/her cereal prior to 9:30am. The resident was not provided the remaining portion of

his/her breakfast meal until almost thirty minutes later. Eggs were not available or offered to the resident.

Resident #35
April 24, 2014 – Resident #35 was assisted to the dining room at approximately 9:30am and was only offered cold cereal and toast. The resident stated that he/she wanted eggs but was declined by staff. Resident #35 was verbally upset that he/she could not have eggs.
April 25, 2014 – Resident #35 was again assisted to the dining room at approximately 9:30am. After eating his/her cereal, Resident #35 requested eggs but was told by staff that none were available. The resident asked for eggs again several minutes later and was again told no.
The resident's plan of care did not indicate that the resident was a late riser.

Resident #28
April 24, 2014 – Resident #28 was brought into the dining room at 9:50am and staff reheated a bowl of hot cereal and provided toast to the resident. No eggs were available to the resident. The resident's plan of care did not indicate that the resident was a late riser.

Resident #29
April 24, 2014 – Resident #29 was brought into the dining room at 9:53am.
April 25, 2014 – Resident #29 was brought into the dining room at 10:00am.
Resident #29's plan of care did not indicate that the resident was a late riser.

Resident #9
April 24, 2014 – Resident #9 was brought into the dining room at 10:08am and provided cold cereal that he/she did not eat. The resident was then provided toast and cheese at 10:15am which the resident did not eat. The resident was not provided assistance with the breakfast meal and was observed at 10:43am with the toast and cheese in front of Resident #9 not eaten.
April 25, 2014 Resident #9 was observed with cold cereal sitting in front of his/her at 8:55am. The nutritional service aide provided the resident verbal encouragement twice but the verbal encouragement was ineffective and the resident was not eating. The nutritional service aide provided the resident a waffle at 9:35am but the resident did not eat. Minutes later, the resident's family member came into the dining room and provided physical assistance to the resident which was effective.
The plan of care for the resident states that the resident is high nutritional risk

and requires one person to assist with eating. The plan of care further stated that Resident #9 was to receive fortified hot cereal at breakfast, with raisin toast and half a banana which the resident did not receive. Further, the resident's care plan did not indicate that the resident was a late riser.

Resident #30
April 25, 2014 – Resident #30 was observed in the dining room at 8:55am with a bowl of hot cereal and a glass of apple juice. The resident was attempting to fed self but was having obvious difficulty. The resident continued to struggle to feed self until 10:05am, an hour and ten minutes later when a PSW sat with the resident to provide the resident some toast. No egg was offered to the resident as none was available. The resident's care plan states that the resident requires extensive assistance with meals and that straws are to be used with beverages. No straws were provided to the resident.

Resident #31
April 25, 2014 – Resident #31 was assisted to the dining room at 10:12am and provided a meal. The resident's plan of care states that the resident is to have prune juice at the breakfast meal. Prune juice was available in the dining room but not offered to the resident. Further, Resident #31's care plan did not indicate that the resident was a late riser.

Resident #29
April 24, 2014 – Resident #29 was brought to the dining room at 9:53am.
April 25, 2014 – Resident #29 was brought to the dining room at 10:00am.
Resident #29's plan of care did not indicate that the resident was a late riser.

Resident #17
April 25, 2014 – Resident #17 was brought to the dining room at 9:40am and was not provided a meal until over thirty minutes later when the resident was provided cold cereal and milk. The resident was assisted with his/her cereal but no other food was offered to the resident including toast. The resident's plan of care states that the resident is high nutritional risk, underweight and has a history of weight loss. Further, the care plan does not indicate that the resident was a late riser.

Resident # 37
April 25, 2014 – LTCH Inspector #138 observed Resident #37 being assisted by a tablemate at 9:23am. The tablemate stated to LTCH Inspector that Resident

#37 was blind and needed assistance with meals. It was noted by the LTCH Inspector that staff did not provide assistance to Resident #37 in eating his/her meal. Resident #37's plan of care stated that the resident had limited abilities to complete activities of daily living due to blindness and cognitive impairment and that the resident required assistance with eating.

In addition to the identified concerns with the breakfast routine on Waterford House and Wexford House, it was observed that the licensee failed to offer all resident on these two units with a mid-morning beverage in accordance with O. Reg 70/10 section 71 (3) (b).

LTCH Inspector #138 was on Waterford House on April 22, 2014 and monitored resident care from 8:35am through to the set up of the lunch meal after 11:45am. The LTCH Inspector did not observe that beverages were offered or provided to all residents between breakfast and the lunch meal. The LTCH Inspector spoke with the RPN, Staff #104, who stated that the morning between meal beverages would be provided if a resident asked for one. The LTCH Inspector noted that there were several residents on Waterford House who are not capable of asking for beverages.

LTCH Inspector #138 arrived on Waterford House the following day on April 23, 2014 at 9:20am and monitored resident care through to the set up of the lunch meal service. It was observed again by the LTCH Inspector that beverages were not offered or provided to all residents.

LTCH Inspector #138 proceeded to Wexford House on April 24, 2014 and arrived on the unit at 8:30am. The LTCH Inspector stayed on the unit until 11:30am to monitor resident care. It was observed by the LTCH Inspector that not all residents were offered or provided a mid-morning beverage. The LTCH Inspector spoke with a PSW, staff #116, who stated that residents would only be provided a mid-morning beverage if they requested a beverage. It was observed by the LTCH Inspector that, like Waterford House, Wexford House had several residents who are not capable of asking for a beverage.

LTCH Inspector #138 arrived on Wexford House at 8:55am and monitored resident care until the noon lunch meal was underway. It was observed by the LTCH Inspector that mid-morning beverages were not offered or provided to all residents on Wexford House that morning. The LTCH Inspector spoke with the RPN, Staff # 121, who stated that a mid-morning beverage pass was not a usual

part of the unit's morning routine.

While LTCH Inspector #138 was monitoring care on Waterford House on April 22, 2014 it was noted that two residents were placed in the lounge across from the dining room and were not released from their physical device or repositioned in accordance with O. Reg 79/10 section 110. (2) 4.

Specifically, LTCH Inspector #138 was on Waterford House the morning of April 22, 2014 and observed, prior to 9:07am, that Resident #2 and Resident #4 were seated in the lounge across from the dining room. Resident #2 was observed in a wheelchair with a lap belt and a table top in place on the wheelchair. Resident #4 was also observed in a wheelchair and was wearing a lap belt. LTCH Inspector #138 continued to observe these two residents until 11:45am. The LTCH Inspector did not observe that Resident #2 was released from the lap belt or table top and repositioned nor was Resident #4 released from the lap belt and repositioned. The duration of time the residents were observed was more than two and a half hours.

Discussion was held with the RN for the fifth floor, Staff #125, on April 28, 2014 regarding the LTCH Inspectors observations about the morning care provided on fifth floor. Staff #125 stated that the morning care is very challenging and that staff are not able to get all the residents up in time for breakfast. She further stated that the residents who are taken to the dining room late for breakfast are late because of staff and not because of the residents' wish to be a late riser. She further stated that the staff continue to discuss alternatives to rectify the concerns.

Discussion was held with the VP Resident Care on April 29, 2014 regarding the provision of care in the mornings on the fifth floor. The VP Resident Care stated that she is aware of the challenges on fifth floor. She stated that one of the strategies being worked on in the home is to ensure consistent staffing on the unit so that staff are familiar with the care needs of the unit.

The scope of the situation was identified to impact, minimally, 24 / 64 residents on Waterford House and Wexford House units, and presented a variety of nutrition, hydration and potential skin breakdown risks. In addition, the observed morning routines are not conducive to promoting resident dignity and respect.

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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During this Resident Quality Inspection, the LTCH Inspector #138 received a call from a resident family member of a resident on 5th floor, expressing concerns about the lack of care being provided to residents on the 5th floor and the lack of improvement in resident care since LTCH Inspector #138's inspection of same units on March 13, 17 and 19, 2014.

The home has a history of non-compliance with the following:
- O.Reg. 79/10 s. 71 (3) (b) related to the lack of between meal beverage in the morning on Waterford House (WN) , from inspection dated on March 13, 17 and 19, 2014 Inspection # 2014-128138-0011
- LTCHA s. 8 (1) (b) related to the lack organized program of personal support service to meet the assessed needs of the residents' morning care on Waterford House (VPC),
from inspection dated on March 13, 17 and 19, 2014 Inspection # 2014-128138-0011
- O.Reg. s. 110 (2) 4 related to the lack of release from a physical device and repositioning at least once every two hours (VPC) , from inspection dated on March 13, 17 and 19, 2014 Inspection # 2014-128138-0011 (138)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jul 01, 2014

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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**Order # / Ordre no :** 002

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that residents who have physical devices for the purpose of restraining meet all of the legislated provisions and requirements related to the use of physical devices in their plans of care.

The plan shall include training for all staff on the application, assessment, monitoring, repositioning, removal and documentation related to the use of physical devices for the purpose of restraining and legislated requirements.

This plan must be submitted in writing to Paula MacDonald and Lyne Duchesne, LTCH Inspectors at 347 Preston St, 4th floor, Ottawa, ON K1S 3J4 or by fax (613) 569-9670 on or before May 16, 2014.

While this plan is being prepared, the licensee must ensure the following:

- The home shall identify all residents who are wearing physical devices for the purpose of restraining and will ensure that the devices are applied as per manufacturers instructions.

**Grounds / Motifs :**

1. The licensee failed to comply with LTCHA s. 31 (1) in that several residents were restrained by a physical device as described in paragraph 3 of subsection 30 (1) and their plans of care did not meet all of the provisions and requirements for restraining by physical devices.

During the Resident Quality Inspection conducted at St Patrick's Home form April 14 to the 29, 2014, the following areas of non-compliance were identified related to the consent, application, monitoring, reassessment and removal of

restraints and that their use was not documented as per legislated provisions and requirements under LTCHA s. 31 (2) and (3).

1) The LTCHA s. 31 (2) 5) states the following: The restraining of residents has not been consented to by the resident, if the resident is incapable, a substitute decision maker of the resident with authority to give that consent. This is issued under WN # 02 in the Inspection Report.

A) The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 31 (5) in that the restraining of two residents have not been consented to by the residents or, if the residents are incapable, by their substitute decision-maker with authority to give that consent.

i) Resident #740 was admitted to the home in December 2012. A physician's order dated on a specific day in June 2013 indicates Resident #740 is to have a safety belt with a ten pound clasp applied when up in wheel chair. A fall risk assessment completed on an identified day in July 2013 indicates that Resident #740 is at a high risk for falls.

A review of the Resident's medical record indicates that physical restraint use is included in the resident's care plan. The care plan also states that a valid consent is to be on the chart prior to initiating the use of the restraint.

A review of the homes policy entitled Restraints: Use of Least Restraints Part II-L29 with a revision date of October 15, 2011 states that the prescribing clinician should ensure that an informed consent is obtained for the treatment from the resident and/or the substitute decision-maker.

A review of the home's mandatory annual staff education material currently used by the home states that informed consent must be obtained for the use of restraints.

Registered staff member #S118 reviewed the resident's medical record with Inspector #556 and could not locate a signed consent. Staff member #S118 stated that there is supposed to be a signed consent for every restraint. The licensee has failed to obtain consent from Resident #740 or the Resident's Substitute Decision Maker for restraint by a physical device.

ii) Resident #21 was admitted to the home on a specified day in February 2014.

The resident is noted to have cognitive impairments and his/her family member is the designated substitute decision maker.

Chart documentation indicates that at the time of admission, the resident's family member informed the home that the resident is to have his/her wheelchair lap belt applied at all times as Resident #21 is at high risk for falls. The family member reported that Resident #21 had sustained a fall with injuries two days prior to his/her admission. On the day of admission in February 2014, the attending physician wrote an order for a wheelchair lap belt to be applied for safety when the resident is up in his/her wheelchair.

Interviewed registered staff members S#152 and S#149 stated to Inspector #117 that the resident was not able to undo the lap belt by him/herself and therefore the lap belt was a restraint. They report that the lap belt was applied when the resident was up in his/her wheelchair. No consent, verbal or written, for the use of wheelchair lap belt found in resident's chart

2) The LTCHA s. 31 (3) states the following: If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that: (b) the resident is monitored while restrained, in accordance with the requirements provided for in the regulations; (c) the resident is released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations; (d) the resident's condition is reassessed and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations; (g) any other requirements provided for in the regulations are satisfied.

The following findings of non-compliance are issued under O.Reg. 79/10 s. 110 WN # 22 of the Inspection Report.

i. The licensee failed to comply with O. Reg 79/10 section 110 (1) 1 in that the licensee failed, with respect to the restraining of a resident by a physical device under section 31 of the Act, to ensure that staff apply the physical device in accordance with any manufacture's instruction.

i) On April 23, 2014 Inspector #556 observed Resident #740 sitting in a wheel chair in the dining room with a seat belt applied six inches too loose.

A review of the resident's medical record indicates there is a physician's order dated on a specific day in June 2013 for wheel chair with safety belt with a ten pound clasp.

A review of the homes policy entitled Restraints: Use of Least Restraints Part II-L29 with a revision date of October 15, 2011 states Care Plan is to outline specific steps for applying and reapplying the device according to instructions given in the order and to manufacturer's instructions and specifications; specify instructions in the care plan.

A review of the resident's care plan indicates that physical restraint use is included in the resident's care plan however there is no indication of how the restraint device is to be applied.

Staff member #S130 who gave morning care to Resident #740 on April 23, 2014 stated that the seat belt was about five or six inches too loose but the seat belt was stuck and could not be tightened. Staff member #S130 further stated Resident #740 doesn't move, and while it's not good for the seat belt to be loose like that, the resident stays put and is therefore not at risk. She stated that the seat belt does need to be applied because it is part of the resident's care plan.

Registered staff member #S120 observed the seat belt on the resident and stated that there should only be room to put a flat hand between the resident and the seat belt and proceeded to tighten the seat belt on Resident #740 while Inspector #556 was present. Registered staff member #S120 further stated that the seat belt had not been applied correctly.

ii) On April 15, 2014 Inspector #573 observed Resident #620 sitting in a Broda wheel chair with a lap belt that was not positioned across the hips and had more than approximately 7 inches between the belt and pelvic crest.

iii) On April 16, 2014 Inspector #573 observed Resident #615 sitting in a wheel chair with a 4 point lap belt the outer one strap is not secured properly, the lap belt was also observed to be loose as evidenced by a greater than 10 inches between the belt and pelvic crest.

On April 29, 2014 the Licensee contracted occupational therapist confirmed during an interview with Inspector #573 that the wheel chair seat belt has to be

applied properly. Definitely not too tight or loose, there should be a finger width space between the belt and the hips, the seat belt has to be snug fit so that it prevents residents sliding out from the wheel chair.

iv) On April 22, 2014, LTCH Inspector #138 observed Resident #3 seated in a wheelchair with a lap belt applied loosely over the resident's hips. The LTCH Inspector noted that the lap belt could be pulled four to six inches away from the resident's body. LTCH Inspector #138 spoke with the unit RPN, Staff #104, who examined the resident's lap belt and agreed that it was too loose. Staff #104 worked with Staff #102 to readjust the resident's lap belt so that it properly fit the resident.

v) On April 24, 2014, LTCH Inspector #138 was observing a breakfast meal service and observed that Resident #17 was in a wheelchair with a lap belt applied very loosely around the hips. Upon further observation, the LTCH Inspector noted that the lap belt could be pulled six to seven inches away from the resident's body. LTCH Inspector #138 spoke with the unit RPN, Staff #15, who examined Resident #17's lap belt and stated that she agreed that it was too loose. Staff #17 stated that she would call to have someone come and adjust the lap belt to fit the resident properly. LTCH Inspector #138 followed up the next day and noted that the resident's lap belt was properly fitting.

B) The licensee failed to comply with O.Reg 79/10, s.110 (2) (6) in that the resident's condition was not reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

i. Resident #555 has advanced dementia, is identified as being at high fall risk and has a lap belt front buckle restraint as a fall prevention intervention.

A review of the resident's health care record was conducted by Inspector #117. It was noted that the resident's current plan of care identifies that the resident has a lap belt restraint. However no documentation was found related to the monitoring of the application, the repositioning and the removal of the resident's lap belt restraint. Also no information related to the assessment of the resident's

condition and the effectiveness of the restraining was noted to be evaluated by a member of the registered nursing staff, at least every eight hour.

Staff member S#106, reviewed the resident's health care record with Inspector #117 on April 22, 2014. She stated to that she was not aware of any process for registered nursing staff to monitor resident's condition when a restraint is applied. Also, S#106 stated that she could not find any documentation in the resident's record indicating that when staff apply the resident's lap belt, when the resident is being repositioned and the lap belt removed.

C) The licensee failed to comply with O. Reg 79/10 section 110. (7) (5, 6, 7 and 8) in that the licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented.

i. Resident #555 has advanced dementia, is identified as being at high fall risk and has a lap belt front buckle restraint as a fall prevention intervention.

A review of the resident's health care record was conducted by Inspector #117. It was noted that the resident's current plan of care identifies that the resident has a lap belt restraint. However, no documentation was found related to the application of the lap belt restraint; the assessment, reassessment and monitoring, including the resident's response; the release of the device and all repositioning; as well as the removal of the resident's lap belt restraint.

Staff member S#106, reviewed the resident's health care record with Inspector #117 on April 22, 2014. Restraint initiation/monitoring/documentation flow sheets were found for the months of January, February and March 2014. The March 2014, flow sheet indicates that on 15/31 day shifts and on 6/31 evening shifts there is no documentation related to the application / monitoring / repositioning and removal of Resident #555's lap belt.

No information was found related to the application / monitoring / repositioning and removal of Resident #555's lap belt for the month of April 2014. S#106 stated that she could not find any documentation in the resident's record indicating that nursing staff were currently documenting the application / monitoring / repositioning and removal of Resident #555's lap belt.

ii. Resident #21 was admitted on a specified day in February 2014. It is noted

that the resident had previously been admitted to the home in late November 2013. At the time of the resident's admission, the resident's family member informed the home's Admission Coordinator S#152 that the resident had sustained several falls in the past few weeks, including a fall, with bruising injuries, that had occurred two days prior to Resident #21's February admission. The resident's family member also informed the home's Admission Coordinator that when the resident is seated in his/her wheelchair, the wheelchair lap belt restraint needs to be applied at all times due to the resident risk for falls. This information was given to Inspector #117 by the resident's family member on April 23, 2014 and confirmed that same day with the Admissions Coordinator S#152. Progress notes document that four days after his/her admission, Resident #21 fell out of the wheelchair as the lap belt had not been applied

A review of Resident #21's health care record was conducted in the presence of S#152 on April 24, 2014. No plan of care and no Restraint Initiation / Monitoring / Repositioning record was found in the resident's chart. On April 24, 2014, staff members S#149 and S#150 stated to Inspector #117 that they did provide care to Resident #21 during his/her stay at the home. However, there is no documentation found in the resident's chart related to the application, monitoring, repositioning and removal of the resident's lap belt. (log #O-000215-14)

D) The licensee failed to comply with O. Reg 79/10 section 110. (7) (5 and 7) in that the licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented.

i. LTCH Inspector #138 reviewed the health care record for Resident #2 and Resident #4 after observing that both residents had not been released from their restraints and repositioned in accordance with O. Reg 79/10 s. 110, (2) 4 on April 22, 2014. The current care plan for Resident #2 stated that the resident was to be in a tilt wheelchair with a lap belt and a table top on the wheelchair as a physical restraint and the current care plan for Resident #4 stated that the resident was to wear a lap belt as a physical restraint.

Staff member S#102 stated to LTCH Inspector #138 that the documentation of all restraints was completed by the PSWs on the Restraint Monitoring Record found in the flow sheet binder for the residents. The LTCH Inspector reviewed the flow sheet binder and observed for Resident #2 that the Restraint Monitoring Record was not consistently completed in that twenty five of the forty two

required entries for April 1 - 21, 2014 regarding restraint use were left blank. The LTCH Inspector was unable to locate a Restraint Monitoring Record for Resident #4.

ii. On April 24, 2014, LTCH Inspector #138 observed during a meal observation that a lap belt applied to Resident #17 was not applied in accordance with O. Reg 79/10 section 110 (1) 1. The LTCH Inspector reviewed the resident's health care record and noted that the resident is planned to wear a physical restraint.

LTCH Inspector #138 spoke with staff member S#122, regarding the documentation of application and release of restraints. Staff member S#122 stated that the documentation is completed by the PSW's on the Restraining Monitoring Record but stated that this documentation is a current challenge for the home and acknowledged that it is not consistently completed and that the Restraining Monitoring Record may not even be able for documentation.

E) The licensee has failed to comply with O.Reg. 79/10, s. 110 (8) (5) in that the release and repositioning of Resident #740 from a physical device was not documented on ten separate shifts in April 2014 no documentation was completed.

i. A physician's order dated on a specific day in June 2013 indicates Resident #740 is to have a safety belt with a ten pound clasp applied when resident is up in wheel chair.

A review of Resident #740's care plan indicates that staff are to check resident and release restraint as per facility protocol.

A review of the homes policy entitled Restraints: Use of Least Restraints Part II-L29 with a revision date of October 15, 2011 states the interdisciplinary team is to document every hour on the restraint monitoring record and every two hours when the restraint is released and the resident is repositioned.

A review of the Restraint Monitoring Record for April 2014 on Resident #740's medical record indicates that on 6 day shifts in April and on four evening shifts in April there was no documentation to indicate that Resident #740 had been released and repositioned at least once every two hours, however progress notes on each of those days indicate that the resident was present in the home. (s.31)

The scope of the situation was identified to impact, minimally, 8 residents presenting with multiple legislated provisions and requirements that are not being met related to physical devices being used for restraining residents.

The home has a history of non-compliance with the following:
- O. Reg 79/10 s. 110. (2) 1 – physician approval of a physical device used as a restraint (WN, VPC) from inspection dated March 13, 17 and 19, 2014 Inspection # 2014-128138-0011
- O. Reg 79/10 s. 110. (2) 4 – released and repositioned from a physical device (WN, VPC) from inspection dated March 13, 17 and 19, 2014 Inspection # 2014 -128138-0011

The issues identified present a risk of harm to residents and given the nature and scope of the issues listed above as well as the compliance history of the home, an Order is being issued.

(117)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jul 01, 2014

## 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

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

and the Director

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
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

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
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

**Issued on this 9th day of May, 2014**

**Signature of Inspector / Signature de l'inspecteur :** Lyne Duchesne RN #117.

**Name of Inspector / Nom de l'inspecteur :** LYNE DUCHESNE

**Service Area Office / Bureau régional de services :** Ottawa Service Area Office