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Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 5, 2015	2015_321501_0016	023254-15	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF SIMCOE
1110 Highway 26 Midhurst ON L0L 1X0

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

SUNSET MANOR HOME FOR SENIOR CITIZENS
49 RAGLAN STREET COLLINGWOOD ON L9Y 4X1

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

SUSAN SEMEREDY (501), GORDANA KRSTEVSKA (600), JOANNE ZAHUR (589)

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): August 31, September 1, 2, 3, 4, 8, 9, 10, 11, 14, and 15, 2015.

The following critical incidents were inspected concurrently: CSC #001239-14 and #001357-15.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, the acting Director of Care (a-DOC), Program and Support Service Manager, Environmental Services Supervisor, Dietary Supervisor, Personal Support Workers (PSWs), Registered Dietitians (RDs), Food Service Supervisor (FSS), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Housekeeping Aides, Private Care-givers, Family Council (Forum) President, Resident Council President, Program Aides, Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, Medical Director, residents and Substitute Decision Makers (SDMs).

During the course of the inspection, the inspector(s) conducted a tour of the home, observed meal service, medication administration system, staff and resident interactions and provision of care, and reviewed health records, complaint and critical incident record logs, staff training records, meeting minutes for Residents' Council and Family Council (Forum) and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
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

During the course of this inspection, Non-Compliances were issued.
11 WN(s)
6 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents' right to be told who is responsible for and who is providing the resident's direct care is fully respected and promoted.

On September 11, 2015, observations revealed three identified PSWs were not wearing their name tags. Interview with the above mentioned PSWs revealed they were aware that residents have the right to know who is providing the resident's direct care and they should have been wearing their name tags in order to respect this right.

Interview with the acting Administrator confirmed that all staff in the home are expected to wear name tags. [s. 3. (1) 7.]

2. On August 31, 2015, observations revealed that two identified registered staff were not

wearing name tags. On September 3, 2015, observations revealed that another identified registered staff was not wearing a name tag.

Interviews with the above mentioned registered staff revealed that it is the home's expectation that name tags are to be worn.

Interview with the acting Director of Care (a-DOC) confirmed that it is the home's expectation that staff wear name tags to ensure the residents' right to be told who is responsible for and who is providing the resident's direct care is respected. [s. 3. (1) 7.]

3. The licensee failed to ensure every resident has the right to have his/her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act.

On August 31, 2015, observations revealed the medication cart on an identified resident home area (RHA) was left unattended with the electronic medication administration record (e-MAR) open to an identified resident's personal health information (PHI). An identified registered staff was observed to be in the dining room and did not have the medication cart in his/her line of vision.

On August 31, 2015, observations revealed the medication cart on an identified RHA was left unattended with the e-MAR screen open to the 12 noon medication administration pass exposing PHI for four identified residents. An identified registered staff was observed to be exiting the medication room where he/she did not have the medication cart in his/her line of vision.

Interviews with the above mentioned registered staff revealed and confirmed that when the medication cart is left unattended the e-MAR screen is to be locked. [s. 3. (1) 11. iv.]

4. On September 11, 2015, at 8:15 a.m., the inspector observed the medication cart located on an identified home area. There was a sitting area with a group of approximately eight residents and private caregivers. The cart was not attended and the computer screen was open revealing an identified resident's personal health information. The inspector was able to observe the resident's name, medical diagnosis, allergies and medications.

Interview with an identified registered staff revealed he/she was not aware of the home's practice to protect the resident's personal health information. Furthermore he/she

confirmed that he/she was not aware of how to manage the screen to prevent the health information being exposed to the public.

Interview with other identified registered staff confirmed the practice in the home is that staff are to close the screen before they move away from the medication cart, to protect resident health information and respect resident privacy. [s. 3. (1) 11. iv.]

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 residents' right to be told who is responsible for and who is providing the resident's direct care is fully respected and promoted and to ensure every resident has the right to have his/her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the plan, policy, protocol, procedure, strategy or system in place is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Record review of the home's policy titled Skin and Wound Management Program, policy number NPC E-30, dated April 2011, revealed that a referral to the interdisciplinary team was indicated for impaired skin integrity of stage II or greater.

Interview with an identified registered staff revealed that it was the home's practice that any stage II or greater impaired skin integrity were referred to the interdisciplinary team.

Interview with an identified registered dietitian revealed that he/she would not expect a referral for any impaired skin integrity less than a stage II. He/she further stated it had been the home's practice to send referrals for impaired skin integrity that were a stage II or greater.

Interview with the acting DOC revealed that a review of the above mentioned skin and wound care program was initiated in November 2014 and remains in progress to date. Acting DOC further stated that no education had been provided to staff and the revised skin and wound program policy would be rolled out in November 2015.

Interview with the acting DOC confirmed that the Skin and Wound Management Program, policy number NPC E-30 was not in accordance with all applicable requirements under the Act. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan, policy, protocol, procedure, strategy or system in place is in compliance with and is implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure an identified resident was protected from abuse and not neglected by the licensee or staff.

O. Reg. 79/10 defines physical abuse as, the use of physical force by anyone other than a resident that causes physical injury or pain. Neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Record review of a critical incident report revealed that on an identified date, an identified resident was allegedly abused physically during evening care when an identified PSW rubbed an identified area on the body with a cloth firmly causing impaired skin integrity as evidenced by blood on the cloth. This incident was witnessed by another identified PSW and an identified registered staff.

Record review of the home's internal investigation notes revealed that an identified registered staff addressed the identified PSW on two occasions on the identified evening, to provide care to residents and was also observed by this registered staff checking personal emails on the home's computer. At 9:40 p.m., the identified registered staff noted that the identified resident was still up in his/her wheelchair and instructed the identified PSW to provide evening care to the resident. The identified registered staff went to the resident's room to ensure care was being provided and witnessed the identified PSW wiping the resident's body area roughly, noting drops of blood from the resident dropping to the floor. The identified registered staff admitted he/she did not intervene to stop the PSW's actions toward the resident nor did he/she stay to observe the remainder of care provided.

When interviewed by the home's management the identified PSW denied he/she handled the identified resident roughly causing bleeding, stating there was an open area already present.

The home's internal investigation notes also revealed that the identified PSW did not provide oral care to the identified resident that evening.

Record review of the identified resident's skin assessments prior to this incident revealed no incidence of impaired skin integrity to the above mentioned body area.

Interview with the identified witnessing PSW revealed that while assisting the identified PSW with the identified resident, he/she witnessed this PSW providing care roughly to the resident causing the area to bleed. The witnessing PSW stated he/she told the identified PSW you are being rough which was denied by the identified PSW. The identified witnessing PSW also revealed that he/she did not intervene or stop the PSW's actions towards the identified resident. In hindsight, the witnessing PSW knows he/she should have stopped the actions of the identified PSW to protect the identified resident.

Interview with the identified registered staff revealed he/she witnessed the identified PSW being rough with the identified resident during evening care. The identified PSW was observed using a rough wiping motion with the identified resident calling out. The registered staff revealed he/she did not intervene or stop the PSW's actions towards the resident that evening and did not report the incident to the Director, instead reported to the evening nurse manager.

Interview with the acting DOC revealed that he/she received an email from the identified registered staff on the identified evening regarding the above mentioned incident. The acting DOC immediately initiated an internal investigation which included sending the witnessing PSW home pending the outcome of the investigation. The identified PSW was called at home and informed not to report to work until the investigation was completed. The home's internal investigation revealed that the identified PSW did not respect the identified resident's right to be protected from abuse or from neglect. The identified PSW was terminated from the home.

Further interview with the acting DOC confirmed that the identified resident was not protected from abuse or free from neglect. [s. 19. (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 residents are protected from abuse and not neglected by the licensee or staff, to be implemented voluntarily.

WN #4: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has 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.

Review of an identified resident's progress notes for the period of June to August 2015, revealed on six identified dates, six alterations to skin integrity.

Further record review titled “Wound Assessment Tool”, used for skin assessment did not

reveal if the identified resident was assessed for the identified areas of altered skin integrity.

Interview with an identified registered staff confirmed that staff are expected to assess resident’s skin and complete the “Wound Assessment Tool” when there is identified altered skin integrity. The identified registered staff further revealed the resident, was not assessed using the home's clinically appropriate assessment instrument specifically designed for skin and wound assessment on identified dates. [s. 50. (2) (b) (i)]

2. Review of an identified resident's progress notes revealed an entry on an identified date, where an incident of altered skin integrity to an identified body area.

Record review of the wound assessment tool for the identified resident revealed that a skin assessment was not completed on an identified date, when the resident experienced altered skin integrity.

Interview with an identified registered staff revealed that the above mentioned altered skin integrity required a wound assessment and that he/she did not complete one.

Interview with the acting DOC confirmed that a skin assessment was not completed using the home’s wound assessment tool. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds have been assessed by a registered dietitian who is a member of the staff of the home.

Record review revealed that an identified resident was diagnosed with an area of altered skin integrity on an identified body area on an identified date, and an identified skin condition on another identified date. Review of a nutritional assessment completed on an identified date, by the Food Service Supervisor, revealed the resident had a an area of altered skin integrity and other skin issues as well. Interview with this Food Service Supervisor confirmed he/she should have referred the resident to the RD but did not. Interview with an identified RD and acting DOC confirmed that the identified resident’s altered skin integrity was not assessed by a RD. [s. 50. (2) (b) (iii)]

4. Record review of an identified resident's progress notes and wound assessment tool revealed that a registered dietitian (RD) referral was not completed for altered skin integrity identified on an identified date.

Interview with an identified RD confirmed that a referral was not completed. [s. 50. (2) (b) (iii)]

5. Record review of the progress notes for an identified resident from June, July and August related to alterations in skin integrity, indicated on six identified dates, six various alterations to skin integrity.

Further record review of the dietitian’s assessment instrument revealed that an assessment had not been completed by a registered dietitian (RD) as a member of the staff in the home in response to the alteration in skin integrity.

Interview with an identified registered staff revealed it is not a practice in the home to make a referral to the RD for skin tears and stage I pressure ulcers. The registered staff also stated that the identified resident had not been assessed by an RD when the resident experienced altered skin integrity on the identified dates. [s. 50. (2) (b) (iii)]

6. The licensee has failed to ensure an identified resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers or wounds, was assessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Record review of an identified resident's progress notes revealed that on an identified date, he/she sustained an injury to his/her identified body area which required a dressing to be initiated. Record review of the wound assessment tool revealed that weekly wound assessments had not been completed on the previously mentioned altered skin integrity.

Interview with an identified registered staff revealed that the identified resident's altered skin integrity warranted weekly wound assessments and the assessments had not been completed.

Interview with the acting DOC confirmed that weekly wound assessments were clinically indicated and had not been completed. [s. 50. (2) (b) (iv)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has 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; residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds have been assessed by a registered dietitian who is a member of the staff of the home and that when residents exhibit altered skin integrity, including skin breakdown, pressure ulcers or wounds, are assessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the nutrition care and hydration programs include the implementation of policies and procedures relating to nutrition care.

Review of the home's policy #DM G-35 titled Weight Management Program dated October 2013, indicated that if there is a weight loss or gain of 2.25 kilograms (kg) or greater, the resident shall be reweighed in order to verify the weight change.

Review of an identified resident's weight record revealed a weight gain from July to August 2015 representing a significant increase. Interview with an identified registered staff indicated that PSWs are prompted by the electronic documentation program when a resident needs to be reweighed and could not explain why this did not happen for the identified resident. This registered staff confirmed that even though there was documentation by this registered staff member and the RD that a reweigh for the identified resident was necessary, it was never completed during the month of August 2015.

Review of the RD's assessment on an identified date in August, and interview with the RD revealed that the identified resident's goal to increase weight was changed to maintain weight and a nutritional supplement was decreased based on this potentially inaccurate weight.

Interview with the DOC confirmed that the home was not following their policy to reweigh residents with a weight loss or gain of 2.25 kg or greater. [s. 68. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the nutrition care and hydration programs include the implementation of policies and procedures relating to nutrition care, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

The licensee has failed to ensure that residents with a change of 5 per cent of body weight, or more, over one month are assessed using an interdisciplinary approach.

Review of an identified resident's weight record revealed the resident had an identified amount of weight loss representing a significant change from July to August 2015. Record review and interview with the Food Service Supervisor revealed a referral was made to the RD on August 6, 2015, regarding this weight loss. Interview with the RD confirmed that he/she was aware of the identified resident's weight loss but had not assessed this weight loss due to an oversight. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with a change of 5 per cent of body weight, or more, over one month are assessed using an interdisciplinary approach, to be implemented voluntarily.

WN #7: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

The licensee has failed to ensure that an identified resident was reassessed and the plan of the care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Review of physician diagnoses for an identified resident revealed a diagnosis of an identified skin condition with an onset date in April, 2015. Record review of the minimum data set (MDS) dated in July, 2015 did not indicate the above mentioned diagnosis.

Review of the most recent written care plan indicated a focus of potential for ulceration or interference with structural integrity of layers of skin caused by prolonged pressure, a goal to maintain intact skin integrity over the next quarter and interventions that included turning and repositioning and the reporting of any new skin issues or reddened pressure areas to registered staff. There was no indication of a diagnosis of the identified skin condition.

Interview with the MDS coordinator and the acting DOC revealed and confirmed that the identified resident's MDS was not coded accurately and that the care plan had not been updated. [s. 6. (10) (b)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure 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 has resulted in harm or risk of harm to the resident shall immediately report this to the Director.

Review of a critical incident report revealed that on an identified date, an identified resident was abused during evening care and the acting DOC notified the Director on an identified date, three days later.

Interview with an identified registered staff revealed he/she reported the incident of alleged abuse to the evening supervisor and not immediately to the Director.

Interview with the acting DOC confirmed that the home had failed to notify the Director immediately of abuse towards the identified resident. [s. 24. (1) 2.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Record review of the Family Council (Forum) meeting minutes and interview with the President of the Family Council (Forum) revealed that when family members discuss concerns or recommendations in the meetings, the issues are usually addressed in the next meeting.

Review of the minutes of the meeting on May 7, 2015, revealed there were discussions regarding:
• No sticks or discs for shuffleboard game.
• Ipod music is repeating.
• Families request follow up with nursing regarding shaving of male residents.

Review of the minutes of the meeting on April 9, 2015, revealed there were discussions regarding:
• Administration office often closed.
• Outdoor furniture cushions left out all winter; suggestion to buy chairs that do not need cushions.
• Dining room blinds need repair.
There was no indication that the home followed up in writing to the Council.

Interview with the Program and Support Service Manager confirmed that the home does not respond to the Family Council (Forum) in writing within 10 days but will help to implement this in the future. [s. 60. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator

Specifically failed to comply with the following:

s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. O. Reg. 79/10, s. 212 (1).
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. O. Reg. 79/10, s. 212 (1).
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the home's administrator works regularly in that position on site at the home for at least 35 hours per week.

Interview with the acting Administrator revealed the home had been without a permanent Administrator since the end of May 2015 and a new Administrator would be starting September 14, 2015. Since the end of May, the acting Administrator had been filling in from another home in the County of Simcoe and another person from the County had also been on call. The acting Administrator confirmed that there had not been an Administrator working regularly in that position on site at the home for at least 35 hours per week. [s. 212. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On September 1, 2015, observations conducted on an identified resident home area (RHA) revealed that in two identified shared bathrooms the following items were found to be unlabelled:
-wash basin left in the sink,
-a dirty wash basin left on the counter top,
-three unlabelled toothbrushes on the counter top.

Interview with an identified registered staff revealed and confirmed that the home's expectation is that all resident personal items located in shared bathrooms are to be labelled with the resident's name. [s. 229. (4)]

Issued on this 18th day of November, 2015

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

Original report signed by the inspector.