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

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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
Mar 25, 2013	2013_179103_0009	O-000117-13	Resident Quality Inspection

Licensee/Titulaire de permis

DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC
2121 ARGENTIA ROAD, SUITE 301, MISSISSAUGA, ON, L5N-2X4

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

PERTH COMMUNITY CARE CENTRE
101 CHRISTIE LAKE ROAD, R. R. #4, PERTH, ON, K7H-3C6

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

DARLENE MURPHY (103), AMANDA NIXON (148), LYNDA HAMILTON (124)

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): February 25-28, March 1, 4-8, 2013.

During this Resident Quality Inspection, a critical incident report related to a reported alleged abuse was reviewed, and a Follow up inspection related to door security was completed.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, President of the Resident Council, President of the Family Council, Health Care Aides (HCA), Personal Support Workers (PSW), Restorative Care Aides, Registered Practical Nurses (RPN), Registered Nurses (RN), the RAI/MDS Coordinator, the Physiotherapist, the Physiotherapist assistant, the Activity Coordinator, the Activity aide, the Environmental Coordinator, Housekeeping staff, Laundry staff, the Maintenance Coordinator, the Maintenance staff, the Food Service Manager, the Dietitian, Business office Manager, Business office Coordinator, Business office staff, and the Administrator

During the course of the inspection, the inspector(s) completed a initial walk through of the home, reviewed resident health care records, reviewed policy and procedures related to Abuse, Medication, Dietary, Infection Control, Plans of Care, Nursing Care, Admission process, Safe lifts and transfers, reviewed Quality improvement initiatives, observed dining and snack service and observed medication administration.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Death
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents. O. Reg. 79/10, s. 9. (1).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency. O. Reg. 79/10, s. 9. (1).
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9. (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 9(1) 1. i. and iii, in that the licensee did not ensure that all doors leading to stairways and the outside of the home are: kept closed and locked, are equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and that is connected to the resident-staff communication and response system or connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

There are two sliding doors at the front entrance of the home (an inside and outside sliding door) which lead to an outside unsecured common area and parking lot. The inside sliding door is accessible to residents and is equipped with a key pad. When the code is entered into the key pad this will initiate the inside sliding door to open. Motion detection will open the outside sliding door. On March 8, 2013, Inspector #148, in the company of the home's Maintenance Coordinator (MC), easily pushed open the inside sliding door using the emergency bar (a door feature available for the purposes of emergency exit). Once the inside sliding door was opened, the outside sliding door opened through motion detection, thus allowing for access to the unsecured common area and parking lot. The opening of the sliding doors did not elicit an audible alarm. It was confirmed by the MC and Administrator that both, the inside and outside sliding doors, are not equipped with locks nor is either door equipped with an audible door alarm.

It was confirmed that the doors leading to stairwells and the outside of the home, with the exception of the two front sliding doors, are equipped with magnetic locks and audible alarms. In addition, these doors are connected to an audio visual enunciator (panel) at the first floor nursing station. The Maintenance Coordinator and a Representative from the company who installed the alarm, described that when a door has been left open for ten seconds an audible alarm will sound and the triggered door will be displayed on the panel. The audible alarm can be cancelled at the panel. If cancelled at the panel, the audible alarm is to re-sound after two minutes. The Representative further indicated that while the function to cancel the door alarm is available to staff through the panel, it was not intended to be used to cancel the door alarm.

On March 7, 2013, staff #104 reported that all of the interior and exterior doors including those leading to stairwells and to the outside can be "shut off" at the panel located at the first floor nursing station. The staff member stated that when he/she

hears a door alarm sound, he/she would shut off the audible alarm at the panel and determine from the panel display what door has been activated. The staff member further reported that if the door alarm was a door leading to the outside he/she would go to inspect the reason for activation; however, he/she would not necessarily inspect the reason for activation when it is an interior door that has been activated.

On March 7, 2013 the home's Maintenance Coordinator (MC) and Inspector #148 reviewed the audible door alarm system. Inspector #148, in the company of the MC, activated the stairwell D door alarm on the lower level, then proceeded through the stairwell to the first floor nursing station. As the MC and Inspector reached the first floor stairwell D door, the audible alarm was silenced. Upon reaching the first floor, we observed a staff member moving away from the panel/nursing station area and down a separate corridor (away from the stairwell where the door alarm had been activated). The MC inquired with the staff member if they had silenced the alarm from the panel at the nursing station, the staff member answered "yes". At this time, the MC confirmed that the door alarm can be cancelled at the panel. We observed the panel which continued to display that the lower level door in stairwell D had been triggered, we remained at the nursing station and no further audible alarm sounded. When asked why the audible alarm did not return the MC explained that an active alarm would be cancelled if someone accessed the door using the key pad or green by-pass button, located at the door. Without the audible alarm staff would need to view the panel display to know if a door was activated. The panel is not viewable from stairwell D, and can only be read if in close proximity to the panel. Several staff members were observed to use stairwell D during our observation time, staff moving through these doors would not be aware of the door alarm, as the audible alarm had been silenced.

During observations on March 8, 2013, staff #118 was observed to silence a door alarm from the panel outside the first floor nursing station, without any further investigation into the reason for the door alarm. When asked by Inspector #148, the staff member reported the alarm was related to an interior door and usually the door alarms are triggered by staff members going on breaks. The staff member went on to say that it would take a lot of time to always have to check a door each time a door alarm was triggered.

Staff have the ability to silence the audible door alarm at the audio visual enunciator at the first floor nursing station. This in effect allows the call to be cancelled at the panel. Once an alarm is silenced, persons accessing the door cancel the door alarm by

entering the code into the key pad. These persons would not be aware of an alarm, as it has been silenced.

In addition the MC confirmed that the audible door alarm for doors leaning to stairways and the outside of the home are not connected to the resident-staff communication and response system. There is an audio visual enunciator at the first floor nursing station. However, there is a nursing station on the second floor, in which there is no audio visual enunciator present for doors nearest to the second floor nursing station. [s. 9. (1) 1. i.]

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. 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 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:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 3 (1) 1 whereby residents were not treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

The following examples were reported to the inspectors:
-Resident E reported that on an identified date, he/she advised staff that he/she was feeling unwell and did not wish to get up at that time. The staff stated the resident had to get up anyway and failed to respect the resident's wish to remain in bed.
-Resident F reported being awakened on a regular basis on or about 0300 hours to have continence care completed. The resident confirmed that he/she is not awake prior to the staff entering the room and is often unable to return to sleep. The resident's roommate was able to confirm this information and advised that staff are not always quiet when giving the care. This resident wished to remain anonymous.
-During the on-site inspection, the inspector observed staff #125 approaching an unidentified resident in a wheelchair from behind and stating in a clear, loud voice "Do you have to use the toilet?" Several additional residents and staff were present in the vicinity at that time. The staff member failed to respect the resident's right to be treated with courtesy.
-Resident G reported during morning care, some staff are rushing and are looking at their watches, feeling the time pressure of their tasks. The resident stated, staff that have "no patience can be very hard to take." The resident reported that staff should know that a smile and reapproaching would be more effective. Staff failed to respect the resident's right to be treated with courtesy. (124) [s. 3. (1) 1.]

2. The licensee has failed to comply with LTCHA, 2007 s. 3. (1) 2 whereby residents have not been protected from abuse.

During the course of the on-site inspection, several residents and informants reported incidents of physical and verbal abuse. During the interviews, the residents were observed to exhibit signs of anxiety and fear when the area of abuse was discussed. All of the informants requested anonymity in the reporting of the incidents and were fearful of reprisal.

O. Reg 79/10 s. 2 (1) defines physical abuse as, "the use of physical force by anyone other than a resident that causes physical injury or pain."

Two cognitively intact residents described in detail situations of rough handling. Both

made reference to twisting, pulling and pushing during the delivery of personal care which resulted in pain.

Resident statements to support rough handling included:
- the home should be careful who they hire because "they have some rough ones",
-I don't say anything because staff will yell at you and it will only get worse the next time

A critical incident reporting staff to resident abuse was reviewed during this inspection. In this incident, Resident #39 reported to a family member that he/she had been grabbed and shaken by a PSW and told he/she needed to stay in the room.

Resident #39 told the PSW that she couldn't do that and the PSW stated, "yes, I can do anything I want." The home investigated, the police were notified and the staff member has been charged and remains off work.

O. Reg 79/10 s. 2 (1) defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident."

During the on-site inspection, Resident #24 is cognitively impaired and was observed by inspector #103 making a verbal request. While walking past the resident, staff #121 responded by laughing and repeating the request in a mocking tone. No additional interventions or redirection was observed and the staff member continued to walk away from the resident.

Five informants described staff reactions to residents as follows:
-staff are "short" in their tone, some "raise their voices",
-staff talk roughly to residents,
-staff speak sharply with residents and bullying type behavior addressed to residents has been overheard,
-staff have been known to be "nasty with the residents", bullying the residents despite being previously reported to management,
-95% of staff are good, but some staff are only in it for the paycheck
-staff have been overheard using a disrespectful tone of voice and ignoring the resident when the resident was speaking to them. [s. 3. (1) 2.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 17 (1) (a) whereby the resident-staff communication and response system is not accessible to residents, visitors and staff at all times.

February 26, 2013, the call bell for resident #8 was found behind the bedside table on the floor.
February 28, 2013 at 0958 hour, Resident #43's call bell was observed attached to the bed rail on the farthest side of the bed from where the resident sits. The resident stated, "that's one thing, I have to go so far to get that bell, if they could just put it closer. (124)
February 28, 2013 at 1016 hour, Resident #44's call bell was observed to be wrapped around the lowered bed rail, covered with a blanket and was located on the farthest bed rail from where the resident was seated. (124)
February 26, 2013 at 1052, Resident #7's call bell was observed behind the bedside table. (124)
February 26, 2013 at 0926 hour, Resident #12's call bell was on the floor at the head of the bed. (124) [s. 17. (1) (a)]

2. The licensee has failed to comply with O. Reg 79/10 s. 17 (1) (d) whereby the resident-staff communication and response system is not available at each bed, toilet, bath and shower location used by residents.

On February 26, 2013 on or about 1345 hour during a resident environmental observation, it was noted that the call bell located in a bathroom that is accessed by the four residents in identified rooms was missing. The call bell system is attached to a plastic mount on the wall and is held in place by a metal clip. According to the PSW staff, call bells are often removed and go missing as residents with cognitive impairments remove them. The maintenance staff was notified and replaced the call bell.

On March 8, 2013 on or about 1400 hour, the call bell for the bathroom of the same identified room was once again found to be detached from the wall mount and was located on the floor behind the toilet. [s. 17. (1) (d)]

3. The licensee has failed to comply with O. Reg 79/10 s. 17 (1) (e) whereby the resident-staff communication and response system is not available in every area accessible by residents.

During a walk-through of floors #1 and #2, call bells were not found in the following areas:

Floor #1-main lounge across from the nursing station and the main dining area,
Floor #2-dining area across from the nurses station [s. 17. (1) (e)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10, s. 36 in that the staff did not use safe transferring techniques when assisting residents.

On an identified date, staff #128 was observed independently transferring resident #35 using a mechanical lift.

When advised that staff had been observed doing a one person mechanical lift transfer, the Administrator stated this was not safe and was unacceptable. She stated the home will be providing on site education to all staff working as a reminder that under no circumstances are residents to be transferred by a mechanical lift with one staff member. [s. 36.]

2. On a subsequent identified date, staff #118 advised the inspector that staff #131 had independently transferred three residents using a mechanical lift.

The on-site education provided by the home related to safe transfers was reviewed for the days provided and it was noted that staff #131 had signed off on having received the training on the previous day. This supports the information provided to the inspectors that staff fail to see the seriousness of this issue. [s. 36.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6. (7), in that the licensee did not ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The plan of care related to feeding assistance for Resident #20 indicates that the resident requires prompting and physical assistance. The most recent Minimum Data Set (MDS) assessment notes that the resident needs extensive assistance with one person physical assist.

During the meal observation on March 4, 2013, Resident #20 was seated at a table with three other co-residents and one staff member. The staff member was providing physical feeding assistance to two of the co-residents. At 1232 hours, the resident was provided with soup and between 1232 and 1241 hours only verbal encouragement was provided. At 1242 hours, the resident was provided with verbal encouragement and the staff member placed the soup spoon in the resident's hand, the resident made no attempt to feed self during this time. At 1249 hours, when the staff member had finished feeding the two co-residents, the staff member provided total physical feeding assistance to Resident #20. At 1249 hours the main meal was served to the resident who made no attempt to feed self, only verbal encouragement was provided. Physical assist with the main meal was not provided until 1257 hours. Feeding assistance set out in the plan of care for Resident #20 was not provided as specified in the plan. (148)

Resident #35's plan of care in place at the time of the inspection stated that Resident #35 was a sit/stand lift with the aid of two caregivers for all transfers.

On an identified date, staff #128 was observed independently transferring resident #35 using a mechanical lift. [s. 6. (7)]

2. Resident #2 is at high nutritional risk. Resident #2's plan of care stated that the resident is to receive a prescribed diet with regular fluids in three meals and three snacks.
Staff #104 reported that the process to deliver snacks to residents is through the nourishment pass.
On March 5, 2013, staff #123 reported to the inspector that during the morning nourishment pass, Resident #2 was provided a beverage and no snack.
Staff #104 reported that Resident #2 would not receive a morning snack because only

beverages are offered as part of the morning nourishment pass.
The Dietary Report for March 1-6, 2013 indicated that the resident did not receive a morning snack from March 1-6, 2013 and did not receive three snacks on any of these days.

On May 14, 2012, Resident #3 had an order written for an identified supplement at med pass times and the resident plan of care supported the same information. Resident #3's Medication Administration Records for May 2012, January, February and March 2013 were reviewed and there is no record that Resident #3 received the supplement at medication pass times.

On March 6, 2013, on or about 1030 hour Resident #17 was observed sitting in the lower level. At 1115 hour, the resident advised the inspector that he/she was not offered a beverage during the morning pass and requested orange juice. The inspector requested the drink from a PSW on the first floor who quickly retrieved the juice and left it on the small table in a mug with a lid and a straw. At 1145 hour, the inspector followed up with the resident who stated, "oh, is there juice there?". The mug was still full and the resident completed the juice with the inspector's assistance.

The plan of care was reviewed for Resident#17 and indicated the resident requires extensive assistance from staff to consume all beverages. In addition, the diet orders for all snacks indicates encourage fluids. The staff failed to provide care to the resident as specified in the plan of care. (103) [s. 6. (7)]

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 care set out in the plan of care is provided to residents #2, #3 and #17 as specified in the plan related to the delivery of nutritional care and the transferring of residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 8. (1) in that the licensee did not ensure that the policies regarding the safe transfers of residents as required under O.Reg 30.(1) were complied with.

The home's "Staff Zero Lifting Policy, HS-XVIII-040, Procedure 1. stated that two staff must be present for the entire mechanical lifting procedure.
On an identified date, staff #128 was observed independently transferring resident #35 using a mechanical lift.

On a subsequent identified date, staff #118 advised the inspector that staff #131 had transferred three residents using a mechanical lift independently. (103) [s. 8. (1)]

2. The licensee failed to comply with O. Reg. 79/10, s. 8. (1) in that the licensee did not ensure that the policies regarding the medication management system , O. Reg. 79/10, s.114 were complied with.

The home's policy, 4-2, "Ordering Medications using the Physician's Order Sheet", section E, "Using Physician's Order sheets which are carbonless", procedure 1 stated Fax ALL orders, to pharmacy (medication and non-medication orders).
On May 14, 2012, the Registered Dietitian ordered a supplement for Resident #3.
On March 5, 2013, in reviewing Resident #3's Medication Administration Records for May 2012, January and February 2013, there is no entry to direct staff to administer the supplement.
On March 6, 2013, staff # 132 confirmed that the May 14, 2012 order had not been faxed to the pharmacy.

The home's Medication Policy, 5-1, Expiry and Dating of Medications, Policy 5-1, Procedure 2. stated "Remove any expired medications from stock and order replacement if necessary." and 3.-"Designated medications i.e. eye drops, insulin, must be dated when opened and removed from stock when expired."
On March 4, 2013, the inspector observed that eye drops with an expiry date of December 12, 2012 was found in Resident #36's and Resident #17's medication bin on the medication cart and that eye ointment with an expiry date of March 2, 2013 was found in Resident #37"s medication bin on the medication cart. (103) [s. 8. (1)]

3. The licensee failed to comply with O. Reg. 79/10, s. 8. (1) in that the licensee did not ensure that the policies regarding the organized program of nursing services,

under LTCHA, 2007 S.O, c.8, s.8, were complied with.

A physician's order for Resident #2 and #6 related to an identified treatment failed to follow the policy related to this treatment.
(124) [s. 8. (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 staff comply with the home's policies related to the safe transfer of residents, expired medications and processing of orders, to be implemented voluntarily.

WN #7: 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).

Findings/Faits saillants :

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1. The licensee failed to comply with LTCHA 2007 S.O. 2007, c.8, s.15. (2) (c), in that the licensee did not ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Observations conducted over the course of this inspection noted the following:
- Numerous scraps/black marks along baseboards and walls of the corridors on both floor one and two,
- Scraps/black marks noted in several resident rooms, including inside of shared bathroom doors
- Bathroom for room 261, rusted bracket on over toilet frame
- Bathroom for rooms 265, 223, rusted bathroom sinks
- Room 162, partial baseboard missing in bathroom and broken drywall behind resident's bed including two areas measuring approximately 6 by 3 inches. In addition it was observed that the wall in the bathroom has many black marks and there are screw holes in the wall where toilet bars have been removed, the corner of the doorway going into the bathroom has the baseboard missing and metal stripping is showing as well as the wall
-Room 241-doors inside and outside of bathroom are heavily scarred with paint missing down to the metal in large areas
-Room 264-doorway into the bathroom had areas where there were no baseboards and areas with broken/missing/gouged plaster and steel strapping at wall edges exposed
-Room 147 it was observed that there is paint missing from the bathroom door and the door frame paint is chipped
-tub room on the Margaret Hart wing, a wooden arm chair's padded seat was cracked and rough to touch at the front edge
-Room 161 it was observed that the wall facing the resident's bed has the paint scraped off, showing a different colour of paint underneath. In addition, the paint was peeling and missing from the lower section of this wall in two large and three small areas. The bathroom wall also had peeling paint in one area
-Room 163 it was observed that there is paint peeling off the lower portion of the wall in front of bed one
-Room 165 it was observed that the corner baseboard by the bathroom door is broken
-Room 164 it was observed that the wall behind the bedroom door is scarred with black marks, as well as the wall the bed faces below the television
-Room 166- the bedside table for bed two at the front edge near the bed is rough and the finish is missing

An interview with the Maintenance Coordinator (MC) on March 4, 2013, stated that there is a reliance primarily on the nursing and housekeeping staff to report damaged in the home, including walls and equipment. Housekeeping staff are to do monthly inspections of the rooms, identify any maintenance issues and report those issues to either the Maintenance or Environmental Coordinator so that action may be taken. It was further noted that resident rooms are inspected and repairs provided, as needed, when a room becomes vacant. In addition, the MC also conducts periodic tours to identify maintenance issues in the home. With regards to the home's painting program, the MC reported that painting is done on an as needed basis, as issues are reported by staff; no regular painting program could be identified. In addition, he reported that the home is currently working on plans to install bumper pads in select areas of corridors to prevent further damage. As it relates to rusted grab bars and resident sinks, the home is aware of this issue and the MC noted that many grab bars and nine resident sinks have been removed/replaced. [s. 15. (2) (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 home has in place a system to identify and correct issues related to painting and general wall maintenance, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 71 (3) (b) whereby each resident was not offered a minimum of a between-meal beverage in the morning.

On an identified date, Resident #17 was observed sitting in the lower level. At 1115 hour, the resident advised the inspector that he/she was not offered a beverage during the morning pass and requested orange juice. The inspector requested the drink from a PSW on the first floor who quickly retrieved the juice and left it on the small table in a mug with a lid and a straw. At 1145 hour, the inspector followed up with the resident who stated, "oh, is there juice there?". The mug was still full and the resident completed the juice with the inspector's assistance.

The following day, resident #17 was once again observed to be sitting in the lower level. The inspector noted the beverage pass was completed, but no drinks had been offered or left with resident #17. A staff member leaving the lower level was asked if she could retrieve a drink for this resident. The staff member stated, "they must have been missed during the pass". The staff member promptly returned and was observed offering assistance to resident #17. [s. 71. (3) (b)]

2. The plan of care was reviewed for resident#17 and the diet orders for all snacks indicates encourage fluids.

The morning or afternoon nourishment carts were not observing going to the lower level throughout the inspection period. The activity staff routinely provide beverages to residents that participate in programs in the lower level but do not include residents who lounge in the area in front of the elevator. Staff interviewed stated the cart does not go to this area to provide beverages or snacks [s. 71. (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 each resident is offered a beverage from the nourishment cart regardless of their location within the home, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 131. (2) in that the resident did not receive drugs in accordance with the directions for use specified by the prescriber. Resident #4 did not receive a physician ordered change in medication for a period of two days.

A Medication Error Report was completed and stated that the change in frequency was not reflected on the Medication Administration Record. As well, it stated that the registered staff did not think the new medication was available. The medication was available in the home. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #4 receives medication in accordance with the physician's order, to be implemented voluntarily.

WN #10: 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).

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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 s. 229. (4) in that the staff member did not participate in the implementation of the infection prevention and control program as evidenced by the following finding.
On March 4, 2013, on or about 1200 hours, staff #117 was administering medication and opened the container of Tums and poured two tablets into her hand. Staff #117 then proceeded to drop the Tums tablets from her hand into the resident's medication cup.
Staff #117 had not washed her hands prior to dropping the Tums tablets into her hand. [s. 229. (4)]

2. On March 4, 2013 during the lunch meal, staff #121 was observed assisting a resident in the dining room with a bowl of soup. In an effort to place the soup bowl on an angle to facilitate the resident spooning the remaining soup, the staff member was noted to have her thumb down in the inside of the soup bowl [s. 229. (10) 1.]

3. The licensee has failed to comply with O. Reg 79/10 s. 229 (10) 1 whereby residents admitted to the home were not screened for tuberculosis within fourteen days of admission.

Residents #25, #26, #28, #29, #30 did not receive tuberculosis within fourteen days of admission to the home.

4. The licensee has failed to comply with O. Reg 79/10 s. 229 (10) 3 whereby residents are not offered immunizations against tetanus and diptheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

In an interview with the Administrator and with staff #101, both advised that the home does not offer tetanus or diptheria immunizations to residents. Staff #101 advised tetanus is sometimes given at the hospital as part of an emergency room visit. [s. 229. (10) 3.]

5. The licensee has failed to comply with O. Reg 79/10 s. 229 (10) 4 whereby staff are not screened for tuberculosis and other infectious diseases in accordance with evidence based or prevailing practices.

In an interview with the Administrator and staff #101, staff are not screened for TB or other infectious diseases. Staff are only offered influenza vaccine yearly. [s. 229. (10)

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 all staff participate in the implementation of the infection control program, residents receive TB screening within fourteen days of admission, residents are offered tetanus and diptheria immunizations in accordance with the publicly funded schedules posted on the Ministry website, and staff are screened for TB and other infectious diseases in accordance with best practices or prevailing practices, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s.13, in that the licensee did not ensure that each resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

The room of Resident #5 is occupied by two residents and is equipped with a mechanical lift. The track for the lift crosses over the track used to hang the resident's privacy curtains, which are used to surround the bed during the provision of care. Given the placement of the mechanical lift tracking system, the Inspector and Environmental Coordinator reviewed the capacity of the curtains to provide privacy. It was observed that the curtains could not come together and there was insufficient curtains to provide privacy for this resident. [s. 13.]

2. On February 26, 2013, during resident environmental observations, Resident #40's privacy curtain was noted to be partially hanging from the ceiling track and did not provide complete privacy from the view point of the doorway. The track had no stopper at the end of the track and a piece of masking tape was evident where the stopper should have been as a means of preventing the remainder of the curtain from falling off the track. On March 3, 2013, this privacy curtain was noted to have been completely removed. In an interview with staff #106, she was unaware the ceiling track required a stopper. Staff #106 stated staff should have notified maintenance so that a new stopper could have been installed and the curtain properly hung.

On March 6, 2013, the privacy curtains for Resident #11 was noted to be insufficient to provide complete privacy as a result of the over head ceiling track which prevented the curtains from being fully drawn and resulted in a two to three inch gap which could be visualized from the next resident bed and from the doorway.

The issues related to the privacy curtains for all three of the residents were rectified when the concerns were brought forward by the inspector. [s. 13.]

WN #12: 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, ss. 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, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 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, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 24 (1).

In an identified critical incident report, the home did not notify the Ministry of Health and Long Term Care (MOHLTC) of an alleged staff to resident abuse immediately. [s. 24. (1)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10, s. 30. (1) in that the licensee did not ensure that the procedure to address lingering, offensive odours as required by O. Reg 79/10, s. 87. (2) was in writing.
Throughout the course of the inspection, an offensive odour was present in an identified area. The home has a procedure for addressing incidents of lingering offensive odours but it is not a written procedure. [s. 30. (1)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10, s.37, in that the licensee did not ensure that each resident of the home has personal items labelled within 48 hours of admission and of acquiring, in the case of new items.

Observations made between February 25 and 27, 2013, noted unlabeled personal items were found in two identified areas of the home. [s. 37. (1) (a)]

WN #15: 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 failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 60. (2), in that the licensee does not respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

During an interview with the Family Council Chair, he stated that when a concern or recommendation is brought forward to the home through the council, the home will communicate their actions or response during the next meeting. The Chair noted that the Family Council meets once a month on the second Wednesday of the month, and that given this schedule it is usually a month before the Council receives a response from the home.

An interview with the home's Administrator, stated that communication to the council is rarely done by a written response but rather during the Family Council meetings.

As evidenced by the Family Council minutes and the interview of the Family Council Chair, several issues have been brought forward including: visitor/staff parking, staff documentation, new doors and benches outside and no written response was found. [s. 60. (2)]

WN #16: 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:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

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1. The licensee has failed to comply with O. Reg 79/10 s. 73 (1) 4 whereby residents receiving tray service were not monitored during meals.

On an identified date, residents #18 and #38 were provided tray service in their rooms in accordance with their requests. Both residents were observed by inspector #103 between 1230 and 1315 hours. During this time, both residents were observed to have completed their meals and neither resident received any monitoring by staff.

During an interview with staff #130, she advised the float person is usually assigned to deliver trays to residents eating in their rooms and they would be responsible to check on those people intermittantly throughout the meal.

The plan of care for Resident #38 indicates that the resident is to be supervised at all meals.
The health care record for Resident #18 indicates that the resident has difficulties chewing and swallowing and that staff need to minimize the resident's choking risk. [s. 73. (1) 4.]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)

(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA 2007, S.O.2007, s. 78.(2)(g) as evidenced by the following findings:
Under "Policy on Minimizing of Restraints" in the admission package provided to the inspector, there was a statement that said a copy of the written policy on minimizing restraints was included in the package.
Staff #109 confirmed that the home's policy on minimizing the restraining of residents was not included in the admission package. [s. 78. (2) (g)]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

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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 the LTCHA 2007, s.79. (3)(e) in that the procedures for initiating complaints to the licensee are not posted and communicated. The Administrator confirmed that the procedures for initiating complaints to the licensee are not posted and communicated at this time. [s. 79. (3) (e)]

2. The licensee failed to comply with the LTCHA 2007, s. 79. (3) (h) in that the name and telephone number of the licensee is not posted and communicated.
The Administrator confirmed that the name and telephone number of the licensee is not posted and communicated. [s. 79. (3) (h)]

WN #19: 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. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 85. (3), in that the licensee did not seek the advice of the Family or Resident Council in the development and carrying out of the satisfaction survey.

An interview with the Family Council Chair on March 4, 2013, stated that the 2013 satisfaction survey has been distributed to residents and family members. The Chair could not recall the home seeking the advice of the Family Council prior to the implementation of the current survey.

An interview with the Resident Council President on March 5, 2013, stated that the Residents' Council has not been involved with development or carrying out of the current 2013 satisfaction survey.

The Administrator confirmed that the home is currently in the process of collecting completed 2013 satisfaction surveys. The Administrator further confirmed that the survey is provided by the home's corporate body and that although the family and resident council are notified of the survey distribution, the councils are not involved in the development or carrying out of the survey.(103) [s. 85. (3)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 96 (a) whereby the home's written policy to promote zero tolerance of abuse and neglect of residents does not contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected.

The home's written policy titled, "Zero Tolerance for Resident Abuse and Neglect ", Policy #ADM-VIII-005, under "Procedure and Interventions to Assist Residents" states, provide information and assistance to the resident, the resident's SDM and any other person specified by the resident with respect to contacting community resources. The policy fails to provide specific procedures and interventions to assist and support residents who have been abused/neglected or allegedly abused/neglected. [s. 96. (a)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 104 (1) 2.

In an identified critical incident report submitted by the home to report an alleged abuse, the home failed to include the names of staff members who discovered the incident. [s. 104. (1) 2.]

2. The licensee has failed to comply with O. Reg 79/10 s. 104 (1) 5.

In an identified critical incident submitted by the home, the home failed to include whether an inspector had been contacted in response to the alleged incident of abuse. [s. 104. (1) 5.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg s. 129 (1) (a) whereby drugs are not stored in an area used exclusively for drugs and drug related supplies.

The medication storage area located on the lower level of the home was found to contain personal care supplies and dressing supplies in addition to medication and medication related supplies. [s. 129. (1) (a)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
6. The list of goods and services permitted under paragraph 3 of subsection 91 (1) of the Act that a resident may purchase from the licensee and the charges for those goods and services. O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10, s. 224. (1) 6. in that the admission package did not include the charges for the goods and services that the resident may purchase.
The Non-Funded Services Agreement lists all goods and services that the resident may purchase but the cost of those goods and services is not included.
Staff member #S109 confirmed that the resident/SDM is not provided with a separate list of prices for the goods and services that the resident may purchase. [s. 224. (1) 6.]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 305. Construction, renovation, etc., of homes

Specifically failed to comply with the following:

s. 305. (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions or renovations to the home. O. Reg. 79/10, s. 305 (3).
2. Other work on the home or work on its equipment, if doing the work may significantly disturb or significantly inconvenience residents. O. Reg. 79/10, s. 305 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 305 (3) 1 whereby prior approval of the Director was not received before alterations were made to the existing call bell system in the home.

The Administrator was interviewed and stated she believed the alterations to the call bell system are approximately two years old. She was unable to find a plan that would have been sent by the home to the Director prior to the alterations. Doyon spoke with the previous Administrator of the home, Joyce Firlotte, who confirmed the same. In addition, the Administrator reviewed her files of the previously submitted and approved plans for alterations/renovations, and no plan was found for the alterations to the call bell system. [s. 305. (3) 1.]

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 25th day of March, 2013

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

Darlene Murphy
Lynda Hamilton
Amanda Adj RO

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

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARLENE MURPHY (103), AMANDA NIXON (148), LYNDA HAMILTON (124)
Inspection No. / No de l'inspection :	2013_179103_0009
Log No. / Registre no:	O-000117-13
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 25, 2013
Licensee / Titulaire de permis :	DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC 2121 ARGENTIA ROAD, SUITE 301, MISSISSAUGA, ON, L5N-2X4
LTC Home / Foyer de SLD :	PERTH COMMUNITY CARE CENTRE 101 CHRISTIE LAKE ROAD, R. R. #4, PERTH, ON, K7H-3C6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~JOYCE FIRLOTTE~~ Paulette Doyon

To DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 001

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

Linked to Existing Order /
Lien vers ordre existant: 2012_128138_0036, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9. (1).

Order / Ordre :

The licensee shall ensure that all doors leading to stairways and outside the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be, i. kept closed and locked, ii. equipped with a door access control system that is kept on at all times, and iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and, A. is connected to the resident-staff communication and response system, or B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

Grounds / Motifs :

1. The licensee has failed to comply with O.Reg 79/10 s. 9(1) 1. i. and iii, in that the licensee did not ensure that all doors leading to stairways and the outside of the home are: kept closed and locked, are equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and that is connected to the resident-staff communication and response system or connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

There are two sliding doors at the front entrance of the home (an inside and outside sliding door) which lead to an outside unsecured common area and parking lot. The inside sliding door is accessible to residents and is equipped with a key pad. When the code is entered into the key pad this will initiate the inside sliding door to open. Motion detection will open the outside sliding door. On March 8, 2013, Inspector #148, in the company of the home's Maintenance Coordinator (MC), easily pushed open the inside sliding door using the emergency bar (a door feature available for the purposes of emergency exit). Once the inside sliding door was opened, the outside sliding door opened through motion detection, thus allowing for access to the unsecured common area and parking lot. The opening of the sliding doors did not elicit an audible alarm. It was confirmed by the MC and Administrator that both, the inside and outside sliding doors, are not equipped with locks nor is either door equipped with an audible door alarm.

It was confirmed that the doors leading to stairwells and the outside of the home, with the exception of the two front sliding doors, are equipped with magnetic locks and audible alarms. In addition, these doors are connected to an audio visual enunciator (panel) at the first floor nursing station. The Maintenance

Coordinator and a Representative from the company who installed the alarm, described that when a door has been left open for ten seconds an audible alarm will sound and the triggered door will be displayed on the panel. The audible alarm can be cancelled at the panel. If cancelled at the panel, the audible alarm is to re-sound after two minutes. The Representative further indicated that while the function to cancel the door alarm is available to staff through the panel, it was not intended to be used to cancel the door alarm.

On March 7, 2013, staff #104 reported that all of the interior and exterior doors including those leading to stairwells and to the outside can be "shut off" at the panel located at the first floor nursing station. The staff member stated that when he/she hears a door alarm sound, he/she would shut off the audible alarm at the panel and determine from the panel display what door has been activated. The staff member further reported that if the door alarm was a door leading to the outside he/she would go to inspect the reason for activation; however, the staff member would not necessarily inspect the reason for activation when it is an interior door that has been activated.

On March 7, 2013 the home's Maintenance Coordinator (MC) and Inspector #148 reviewed the audible door alarm system. Inspector #148, in the company of the MC, activated the stairwell D door alarm on the lower level, then proceeded through the stairwell to the first floor nursing station. As the MC and Inspector reached the first floor stairwell D door, the audible alarm was silenced. Upon reaching the first floor, we observed a staff member moving away from the panel/nursing station area and down a separate corridor (away from the stairwell where the door alarm had been activated). The MC inquired with the staff member if they had silenced the alarm from the panel at the nursing station, the staff member answered "yes". At this time, the MC confirmed that the door alarm can be cancelled at the panel. We observed the panel which continued to display that the lower level door in stairwell D had been triggered, we remained at the nursing station and no further audible alarm sounded. When asked why the audible alarm did not return the MC explained that an active alarm would be cancelled if someone accessed the door using the key pad or green by pass button, located at the door. Without the audible alarm staff would need to view the panel display to know if a door was activated. The panel is not viewable from stairwell D, and can only be read if in close proximity to the panel. Several staff members were observed to use stairwell D during our observation time, staff moving through these doors would not be aware of the door alarm, as the

audible alarm had been silenced.

During observations on March 8, 2013, staff #118 was observed to silence a door alarm from the panel outside the first floor nursing station, without any further investigation into the reason for the door alarm. When asked by Inspector #148, the staff member reported the alarm was related to an interior door and usually the door alarms are triggered by staff members going on breaks. The staff member went on to say that it would take a lot of time to always have to check a door each time a door alarm was triggered.

Staff have the ability to silence the audible door alarm at the audio visual enunciator at the first floor nursing station. This in effect allows the call to be cancelled at the panel. Once an alarm is silenced, persons accessing the door cancel the door alarm by entering the code into the key pad. These persons would not be aware of an alarm, as it has been silenced.

In addition the MC confirmed that the audible door alarm for doors leaning to stairways and the outside of the home are not connected to the resident-staff communication and response system. There is an audio visual enunciator at the first floor nursing station. However, there is a nursing station on the second floor, in which there is no audio visual enunciator present for doors nearest to the second floor nursing station.

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 24, 2013

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. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
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.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according

to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA, 2007 s. 3 (1) 1 and 2 to ensure all residents are treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity and to protect all residents from abuse.

This plan shall include:
-additional mandatory education on all types of abuse and on residents' rights which includes some form of sensitivity training. This education is to be given to all staff involved in direct resident care and services
-defined interventions to support staff in the integration of the mandatory education into their day to day practice
-a system to monitor and evaluate staff adherance to the Zero Tolerance of Abuse policy and Residents' Rights.

This plan shall be submitted in writing to Inspector, Darlene Murphy, 347 Preston St., 4th floor, Ottawa, Ontario K1S 3J4 or by fax at 613-569-9670 on or before April 9, 2013. Please ensure the plan includes the log #O-000117-13.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA, 2007 s. 3 (1) 1 whereby

residents were not treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

The following examples were reported to the inspectors:
-Resident E reported that on an identified date, he/she advised staff that he/she was feeling unwell and did not wish to get up at that time. The staff stated the resident had to get up anyway and failed to respect the resident's wish to remain in bed.
-Resident F reported being awakened on a regular basis on or about 0300 hours to have continence care completed. The resident confirmed that he/she is not awake prior to the staff entering the room and is often unable to return to sleep. The resident's roommate was able to confirm this information and advised that staff are not always quiet when giving the care. This resident wished to remain anonymous.
-During the on-site inspection, the inspector observed staff #125 approaching an unidentified resident in a wheelchair from behind and stating in a clear, loud voice "Do you have to use the toilet?" Several additional residents and staff were present in the vicinity at that time. The staff member failed to respect the resident's right to be treated with courtesy.
-Resident G reported during morning care, some staff are rushing and are looking at their watches, feeling the time pressure of their tasks. The resident stated, staff that have "no patience can be very hard to take." The resident reported that staff should know that a smile and reapproaching would be more effective. Staff failed to respect the resident's right to be treated with courtesy. (124) [s. 3. (1) 1.]

(103)

2. The licensee has failed to comply with LTCHA, 2007 s. 3. (1) 2 whereby residents have not been protected from abuse.

During the course of the on-site inspection, several residents and informants reported incidents of physical and verbal abuse. During the interviews, the residents were observed to exhibit signs of anxiety and fear when the area of abuse was discussed. All of the informants requested anonymity in the reporting of the incidents and were fearful of reprisal.

O. Reg 79/10 s. 2 (1) defines physical abuse as, "the use of physical force by anyone other than a resident that causes physical injury or pain."

Two cognitively intact residents described in detail situations of rough handling. Both made reference to twisting, pulling and pushing during the delivery of personal care which resulted in pain.

Resident statements to support rough handling included:
- the home should be careful who they hire because "they have some rough ones",
-I don't say anything because staff will yell at you and it will only get worse the next time

A critical incident reporting staff to resident abuse was reviewed during this inspection. In this incident, Resident #39 reported to a family member that he/she had been grabbed and shaken by a PSW and told he/she needed to stay in the room.

Resident #39 told the PSW that she couldn't do that and the PSW stated, "yes, I can do anything I want." The home investigated, the police were notified and the staff member has been charged and remains off work.

O. Reg 79/10 s. 2 (1) defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident."

During the on-site inspection, Resident #24 is cognitively impaired and was observed by inspector #103 to be making a verbal request. While walking past the resident, staff #121 responded by laughing and repeating the verbal request in a mocking tone. No additional interventions or redirection was observed and the staff member continued to walk away from the resident.

Five informants described staff reactions to residents as follows:
-staff are "short" in their tone, some "raise their voices",
-staff talk roughly to residents,
-staff speak sharply with residents and bullying type behavior addressed to

residents has been overheard,
-staff have been known to be "nasty with the residents", bullying the residents despite being previously reported to management,
-95% of staff are good, but some staff are only in it for the paycheck
-staff have been overheard using a disrespectful tone of voice and ignoring the resident when the resident was speaking to them. [s. 3. (1) 2.]

(103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 29, 2013

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that call bells are accessible to all residents, visitors and staff at all times.

The licensee shall ensure all call bell stations are secured to prevent removal from the location.

The licensee shall ensure call bells are available in every area accessible by residents, including the first floor lounge, first floor dining room and the second floor dining room across from the nurses station.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg 79/10 s. 17 (1) (a) whereby the resident-staff communication and response system is not accessible to residents, visitors and staff at all times.

February 26, 2013, the call bell for resident #8 was found behind the bedside table on the floor.

February 28, 2013 at 0958 hour, Resident #43's call bell was observed attached to the bed rail on the farthest side of the bed from where the resident sits. The resident stated, "that's one thing, I have to go so far to get that bell, if they could just put it closer". (124)
February 28, 2013 at 1016 hour, Resident #44's call bell was observed to be wrapped around the lowered bed rail, covered with a blanket and was located on the farthest bed rail from where the resident was seated. (124)
February 26, 2013 at 1052, Resident #7's call bell was observed behind the bedside table. (124)
February 26, 2013 at 0926 hour, Resident #12's call bell was on the floor at the head of the bed. (124)

(103)

2. The licensee has failed to comply with O. Reg 79/10 s. 17 (1) (d) whereby the resident-staff communication and response system is not available at each bed, toilet, bath and shower location used by residents.

On February 26, 2013 on or about 1345 hour during a resident environmental observation, it was noted that the call bell located in a bathroom that is accessed by the four residents in identified rooms was missing. The call bell system is attached to a plastic mount on the wall and is held in place by a metal clip. According to the PSW staff, call bells are often removed and go missing as residents with cognitive impairments remove them. The maintenance staff was notified and replaced the call bell.

On March 8, 2013 on or about 1400 hour, the call bell for the bathroom of the same identified room was once again found to be detached from the wall mount and was located on the floor behind the toilet. [s. 17. (1) (d)]

(103)

3. The licensee has failed to comply with O. Reg 79/10 s. 17 (1) (e) whereby the resident-staff communication and response system is not available in every area accessible by residents.

During a walkthrough of floors #1 and #2, call bells were not found in the following areas:

Floor #1-main lounge across from the nursing station and the main dining area,
Floor #2-dining area across from the nurses station

(103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 03, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with O. Reg 79/10 s. 36 to ensure staff use safe transferring and positioning techniques when assisting residents.

The licensee will ensure both registered and non registered nursing staff, use safe transferring and positioning devices or techniques when assisting residents by:
-providing education and re-education as necessary on the policies and procedures identified under "Resident Safety Program, #HS-XVIII-020, #HS-XVIII-030 and #HS-XVIII-040", and
-ensuring staff demonstrate their ability to competently and consistently follow the policies and procedures of the home when assisting residents.

This plan shall be submitted in writing to Inspector, Darlene Murphy at 347 Preston St., 4th floor, Ottawa, Ontario K1S 3J4 or by fax at 613-569-9670 on or before April 9, 2013. Please ensure the plan includes the log #O-000117-13.

Grounds / Motifs :

1. The licensee failed to comply with O.Reg. 79/10, s.36 in that the staff did not use safe transferring techniques when assisting residents.

On March 5, 2013 on or about 1330 hours, staff #128 was observed transferring resident #35 using a mechanical lift. Staff #128 confirmed that he was the only staff member in the room. Staff #128 reported that he made the decision to do the transfer by himself and it doesn't happen very often. In addition, he reported he was aware the policy required two staff when transferring with a mechanical

lift.

When the inspector asked staff #123 if all mechanical lifts were done with two staff, staff #123 reported that some staff do mechanical lifts alone, "it depends on who is working."

When advised that staff had been observed doing a one person mechanical lift transfer, the Administrator stated this was not safe and was unacceptable. She stated the home will be providing on site education to all staff working as a reminder that under no circumstances are residents to be transferred by a mechanical lift with one staff member. (124)

On March 8, 2013, staff #118 advised the inspector that staff #131 had transferred a resident using a mechanical lift on her own and that the incident had been reported to staff #101. The inspector followed up with staff #101 who advised she had determined a total of three residents, #41, #30 and #42, had been transferred by staff #131 using a mechanical lift on her own in the tub room.

The on site education provided by the home related to safe transfers was reviewed for March 5, 6 and 7, 2013 and it was noted that staff #131 had signed off on having received the training on the previous day (March 7, 2013). This supports the information provided that staff fail to see the seriousness of this issue. (103)

(124)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 29, 2013

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

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

Ministère de la Santé et des Soins de longue durée

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

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 25th day of March, 2013

Signature of Inspector / Signature de l'inspecteur : Darlene Murphy

Name of Inspector / Nom de l'inspecteur : DARLENE MURPHY

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