Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 27, 2014	2014_168202_0004	T-105-14	Resident Quality Inspection

Licensee/Titulaire de permis

VICTORIA VILLAGE INC.
76 ROSS STREET, BARRIE, ON, L4N-1G3

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

VICTORIA VILLAGE MANOR
78 ROSS STREET, BARRIE, ON, L4N-1G3

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

VALERIE JOHNSTON (202), ANN HENDERSON (559), LAURA BROWN-HUESKEN (503), LYNN PARSONS (153)

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): January 27, 28, 29, 30, 31, February 03, 04, 05, 06, 07, 2014.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing Services (DNS), Associate Director of Nursing Services (ADNS), Director of Dietary & Laundry (DDL), Physiotherapist, Director of Resident and Family Services (DRFS), Restorative Care Coordinator (RCC), Resident's Council Assistant, Recreational Therapist and Volunteer Coordinator (RTVC), Scheduling Coordinator, Unit Coordinator (UC), Food Services Supervisor (FSS), Operations Manager, Projects Coordinator, Registered Nursing Staff, Personal Support Workers (PSW), Housekeeping Staff, Laundry Aides, Dietary Aides (DA), Cooks, Receptionist, Recreation Assistants, residents and families.

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, dining observations, conducted a tour of the home, observed medication storage areas, reviewed the home's menu and recipes, reviewed home's policies related to abuse, falls prevention, continence care, infection prevention and control, safe food handling, food temperatures, reviewed Resident's Council meeting minutes and Family Council meeting minutes, staff educational records, staffing schedule, employee records, resident activity calendar.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with 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:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

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:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the dining and snack service includes a review of the meal and snack times by the Residents' Council.

An interview with the assistant of the Residents' Council revealed that the meal and snack times were not reviewed by the Resident's Council and this was also confirmed in an interview with the DDL. [s. 73. (1) 2.]

2. The licensee failed to ensure that the home has a dining service that includes course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

During a lunch observation on February 6, 2014, resident #0011 and resident #0012 were observed to have both soup and an entrée in front of them. An interview with a PSW indicated that the entrée was served alongside the soup for resident #0012 due to resident preference and that staff had forgotten to remove the soup from resident #0011 when the entrée was served. Review of the clinical records for resident #0011 and resident #0012 did not indicate any exceptions to course by course meal service. The home's Pleasurable Dining Responsibilities and Dining Room Service Process,

Policy XI-I-10.00 current revision September 2010, directs staff to serve one course at a time, unless individual residents request otherwise. An interview with the DDL revealed that residents are to be served meals course by course unless stated otherwise in the resident's care plan. [s. 73. (1) 8.]

3. The licensee failed to ensure that no resident who requires assistance with eating and drinking is served a meal until someone is available to provide the assistance required by the resident.

During the lunch meal service on January 27, 2014, the following was observed:
- Resident #0013 was served soup at 1238h and did not receive assistance until 20 minutes later. Resident #0013's written plan of care directs staff to provide physical assistance to eat.
- Resident #0015 was served soup at 1238h and did not receive assistance until 13 minutes later. Resident #0015's written plan of care directs staff to provide total feeding assistance.
During the lunch meal service on February 6, 2014, the following was observed:
- Resident #0014 received the entrée at 1250h and did not receive assistance until 40 minutes later. The entrée's temperature was taken by a DA and noted to be 60 degrees Fahrenheit, the DA indicated hot food should be served at 140 degrees Fahrenheit. The entrée was then reheated in the microwave and the temperature was reported to be 142 degrees Fahrenheit.
- Resident #0011 received no physical assistance for one hour with his/her soup and the entrée. Resident #0011's written plan of care indicated that the resident requires extensive assistance to eat. Review of resident #0011's clinical records indicated that the resident has experienced a significant weight loss over the previous three months and six months.
The home's Pleasurable Dining policy, VII-I-20.00 original issue November 2013, states that residents requiring assistance in eating shall be served no more than five minutes in advance of the assistance being provided. Interview with the DDL indicated that for each of the instances above the residents should not have been served until assistance was available to them. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no resident who requires assistance with eating and drinking is served a meal until someone is available to provide the assistance required by the resident and that the dining service includes course by course meal service, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Resident #3857 was observed to have a protective dressing applied. A review of the written plan of care for the resident failed to reveal any information about the

resident's skin care requirements despite being identified at risk for skin breakdown in the quarterly skin assessment completed on an identified date. Registered staff interviews confirmed the written plan of care did not include a section related to skin care or interventions for the skin tear. [s. 6. (1) (c)]

2. Resident #3851 was observed to have a protective dressing applied. A review of the written plan of care for this resident failed to reveal any information of the resident's skin tears or treatment intervention. Registered staff interviews confirmed the written plan of care did not include documentation related to skin care interventions for the skin tear. [s. 6. (1) (c)]

3. The licensee failed to ensure that the care set out in the written plan of care is provided to the resident as specified in the plan.

Resident #3796's written plan of care directs staff to provide regular toileting assistance. Staff are to assist the resident to toilet upon waking up, after breakfast, before lunch, after lunch, before afternoon nap, before dinner, after dinner, before bed and when necessary. During staff interviews it was revealed that the resident is only toileted after breakfast, after lunch and after supper. Staff revealed that on an identified date six pairs of wet pants were found in his/her room at the start of day shift and on another identified date, the resident had been found on his/her stripped bed with six pairs of wet pants draped around his/her room. An interview with family members revealed that they are unsure when the resident is toileted. Staff interviews confirmed that the written plan of care for this resident is not being followed. [s. 6. (7)]

4. The written plan of care for resident #3869 directs staff to engage the resident in one group activity weekly, to provide the resident with one to two pastoral visits monthly and to facilitate the resident's attendance to the Catholic service monthly. A review of the clinical records indicated that the resident attended only two group activities in the month of November 2013 and January 2014, the resident was not provided a pastoral visit in the month of January 2014 and the resident did not attend the Catholic service in November 2013, December 2013 and January 2014. An interview with the RTVC confirmed that recreation and spiritual care provided to the resident during the identified months was not provided as specified in the plan of care. [s. 6. (7)]

5. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change or the care set out in the

plan is no longer necessary.

The care plan for resident #3857 directs staff to attach a chair alarm to all chairs that the resident may sit in. Resident #3857 was observed on January 27, 2014 and February 3, 2014 to be seated in chairs in the dining room and unit lounge areas without the chair alarm present and mobilizing on unit with a walker. An interview with a registered nurse revealed that the chair alarm was no longer being used and that the chair alarm intervention for the resident needed to be reassessed. An interview with the RCC further revealed that the resident was now safely mobilizing with a walker and the chair alarm was no longer necessary and that the care plan had not been reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

6. A review of resident #3826's written plan of care directs staff to place both bed side rails up while the resident is in bed to assist in his/her bed mobility. Staff interviews revealed that the resident is unable to reposition him/herself while in bed as he/she has no mobility on his/her left side and limited mobility on his/her right side. Staff indicated that the resident would only be able to use the bed side rails for bed mobility when staff are assisting him/her with care during mechanical lift transfers. Staff confirmed that the resident would not be able to use the side rail to reposition him/herself and requires staff assistance for repositioning. An interview with the RCC revealed that the resident had been assessed on an identified date for the safe use of the bed side rails to assist in his/her bed mobility. The progress notes for the resident revealed that on an identified date, the resident required extensive assistance from staff and was only able to hold onto the bed rails with staff assistance and would fall back without staff assistance. The RCC revealed in an interview that the resident's care needs have changed and confirmed that the current plan of care is no longer necessary. [s. 6. (10) (b)]

7. An interview with resident #3803 indicated he/she has experienced pain for several months. The resident's plan of care has not been revised to include interventions to address the identified factors to reduce the degree of discomfort the resident is experiencing. A referral had not been sent to the a member of the multidisciplinary team for an assessment of the resident's care needs in relation to his/her pain. Interviews with nursing management and registered staff confirmed the plan of care had not been reviewed and revised to address the resident's change. [s. 6. (10) (b)]

8. A review of resident #3857's plan of care identified potential complications related to the administration of an identified prescribed medication and the need to monitor for

side effects. A review of the physician orders revealed the identified prescribed medication was discontinued on an identified date. Registered staff confirmed the resident's plan of care had not been reviewed and revised to reflect the change in order from an identified date. [s. 6. (10) (b)]

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 failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times.

Resident #0016 was observed in bed on January 28, 2014 at 1045h holding the call bell in his/her hand. The call bell was found to be non-functional and this was confirmed by the UC. [s. 17. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident has fallen, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The home's Fall Prevention & Management Policy, VII-G-60.00 original issue November 2013, directs staff to complete the home's Falls Incident Report under the Risk Management portal in the computerized record after a resident has fallen. The ADNS indicated in an interview that the home's clinically appropriate assessment instrument that is specifically designed for falls is the Falls Incident Report. Resident #3857 had multiple documented falls for an identified period of time. Nursing progress notes reviewed for an identified period of time revealed one documented for an identified date. Review of clinical records and an interview with the ADNS confirmed the resident was not assessed using a clinically appropriate assessment instrument that is specifically designed for falls for the fall on the identified date. [s. 49. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

The plan of care for resident #3796 identifies the resident as incontinent and requires assistance from staff for product changes. A review of the clinical records for the resident revealed that the resident had not received an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [s. 51. (2) (a)]

2. The plan of care for resident #3820 and #3907 identifies these residents as incontinent and requiring assistance from staff for toileting and product changes. A review of the clinical records for these residents revealed that both residents had not received an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. The DNS and ADNS indicated that the home does not use a clinically appropriate assessment instrument that is specifically designed for assessment of incontinent residents. [s. 51. (2) (a)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that concerns raised by the Resident's Council were responded to in writing within 10 days.

A review of the Residents' Council meeting minutes indicated that on November 07, 2013, residents raised concerns that the pancakes were not served hot at breakfast and on January 10, 2014 a resident raised concern that he/she was missing five items of laundry. An interview with the DDL and the Administrator confirmed the above Residents' Council concerns and neither of the concerns had been responded to in writing within ten days. [s. 57. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all of the menu items were prepared according to the planned menu.

During the lunch meal service on February 6, 2014, resident #0014 received the entrée at 1250h and did not receive assistance until 15 minutes later. The entrée was returned to the servery by a PSW, who requested it to be reheated and that water be added as the entrée had become too thick. The DA was observed to add water to the pasta primavera portion of the entrée prior to re-heating it in the microwave. Review of the standardized recipe does not include addition of water in production of the pureed pasta primavera. Interview with the DDL confirmed that the DA had not followed the recipe when the water was added. [s. 72. (2) (d)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that copies of the inspection reports from the past two years for the long-term care home are posted.

On January 27, 2014 the following inspection reports were not posted in the home:
#2012_162109_0007
#2012_162109_0006
#2013_162109_0026
The above observation was confirmed by the ADNS. [s. 79. (3) (k)]

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

Specifically failed to comply with the following:

s. 85. (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 did not seek the advice of the Family Council in developing and carrying out the satisfaction survey.

A third party organization was contracted to develop a Resident Satisfaction Survey for 2013 with a direction for Family Council to agree to the survey. Members of the Family Council confirmed that the licensee did not meet with them to seek advice on the development or carrying out of the satisfaction survey. The Family Council did not provide input into the survey questions or the manner the survey would be carried out. [s. 85. (3)]

WN #10: 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 failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents 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.
A review of the home's abuse policy, titled Abuse & Neglect of a Resident-Actual or Suspected, dated November 2013 and an interview with the ADNS confirmed that the home's policy does not include the above legislative requirement. [s. 96. (e)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that where a resident is being restrained by a physical device under section 31 of the Act that staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

During the course of this inspection, resident #3826 was observed to be lying in his/her bed with both 3/4 length side rails raised in an up position. Staff interviews revealed that the resident prefers to have both 3/4 length side rails up while in bed. Staff confirmed that this resident would not be able to reposition him/herself when in a compromised position while in bed and would only be able to release the side rails by requesting staff assistance. An interview with the RCC confirmed that this resident uses both 3/4 length side rails raised while in bed and the bed rail restraint device had not been ordered by a physician or registered nurse in the extended class. [s. 110. (2) 1.]

2. The licensee failed to ensure that where a resident is being restrained by a physical device under section 31 of the Act that the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

During the course of this inspection, resident #3826 was observed to be lying in his/her bed with both 3/4 length side rails raised in an up position. Staff interviews revealed that this resident prefers to have both side rails up while in bed. Staff confirmed that this resident would not be able to reposition himself when in a compromised position. Interviews with registered nursing staff confirmed that when the side rails are used for this resident, the resident is not monitored at least hourly. [s. 110. (2) 3.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes

Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee did not ensure that there is, at least quarterly, a documented reassessment of each resident's drug regime.

A review of resident #3803's clinical health records revealed a reassessment of the resident's drug regime was completed on an identified date. A further review of the resident's clinical health records, failed to reveal a documented reassessment of the resident's drug regime since the identified date. Registered staff confirmed that a reassessment of the resident's drug regime had not been completed at least quarterly as of February 24, 2014. [s. 134. (c)]

WN #13: 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. (12) The licensee shall ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunizations. O. Reg. 79/10, s. 229 (12).

Findings/Faits saillants :

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

During the lunch meal service, on January 27, 2014, a recreation assistant was observed to remove soiled dishes and to serve the following course to different residents with no hand hygiene completed in between. On February 6, 2014 during the lunch meal service, a PSW was observed to remove soiled dishes and serve the following course to different residents with no hand hygiene completed in between. An interview with the DDL revealed that during meal service all staff are expected to utilize the hand sanitizer or wash their hands after they have touched soiled dishes. [s. 229. (4)]

2. The home contracts Therapeutic Inc, a visiting pet therapy program as part of the recreational services provided to residents. A review of the home's contract binder revealed that there was no up-to-date immunization records for the visiting pets and this was confirmed by the RTVC. [s. 229. (12)]

Issued on this 4th day of March, 2014

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

Valerie Johnston.