Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 19, Nov 1, 5, 6, 7, 8, 9, 13, 14, 15, 16, 19, 20, 21, 22, 23, 27, 28, 29, Dec 4, 2012	2012_199161_0003	Resident Quality Inspection

Licensee/Titulaire de permis

DEEM MANAGEMENT LIMITED
2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5

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

WELLINGTON HOUSE NURSING HOME
990 EDWARD STREET NORTH, P.O. BOX 1510, PRESCOTT, ON, K0E-1T0

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

KATHLEEN SMID (161), AMANDA NIXON (148), LINDA HARKINS (126), LYNDA HAMILTON (124), PAULA MACDONALD (138)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Consultants (Extendicare), RAI Coordinator, Food Service Supervisor, Registered Dietitian, Registered Nurses (RN), Registered Practical Nurses (RPN), Food Service Workers (FSW), Cooks, Personal Support Workers (PSW), a student, Therapy Assistant, Recreation Assistant, President of Family Council, President of Residents Council, Office Manager, Maintenance Manager, Environmental Manager, Program Manager, Infection Control Coordinator, Residents, and Family Members.
The inspection occurred on-site November 4-9, 2012, November 12-16, 2012 and November 19-21, 2012.

During the course of the inspection, the inspector(s) During the course of the inspection, the inspector toured the home including resident rooms, resident common areas, and non-resident areas, reviewed resident health records, observed several meal services, observed programming and recreational activities, reviewed policies and procedures related to skin and wound care, resident trust funds, falls, pain.

RQI log # O-000261-12

During the course of the inspection, the inspector(s) conducted four additional inspections:
Complaint Log #O-001174-12, Complaint Log #O-002110-12, Follow-up to Order Log #O-002152-12, Critical Incident Log #O-002109-12

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

Reporting and Complaints

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Training and Orientation

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. 30. General requirements

Specifically failed to comply with the following subsections:

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.
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.
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.
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 :

The licensee failed to comply with O. Reg. 79/10, s. 30. (1) 1. in that not all programs required under sections 8. – 16. of the Act and section 48. of the Regulation are in place.

The Administrator/Director of Care confirmed that she is responsible for leading the Skin and Wound Care Program in the home and reported that the Skin and Wound Care Program is currently not in place. She stated the home is working with a consultant to develop and implement a Skin and Wound Care Program that also includes an evaluation process of the program.

In addition, the Administrator/Director of Care confirmed that the following components of the Skin and Wound Care Program required implementation:

- the skin and wound care committee must be re-established,
- documentation of skin and wound care including updating of the care plan,
- use of assessment tools,
- scheduling of the required assessments by registered nursing staff,
- and accessing skin and wound care specialist to support the home's training needs.

On November 19, 2012, the Administrator/Director of Care reported that the Restorative Care Program has no defined goals, objectives or protocols in place; some care is being delivered to residents.

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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following subsections:

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 comply with O.Reg. 49. (2) in that when a Resident has fallen, a post-fall assessment was not conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #22 fell on a date in November 2012, October 2012 and Sept 2012 and there were no post fall assessments conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

2. It is documented in the progress notes that on a date in September 2012, Resident #27 slipped to the floor while trying to get up from bed. The Administrator/Director of Care and staff member #S101 reported to the inspector that a Post Fall Analysis Report is to be completed after each Resident fall and is documented in Point Click Care.

There was no Post Fall Analysis Report recorded in Point Click Care for Resident #27's fall on a date in September 2012.

3. Resident #2 was found on the floor of bathroom at 2230 hours after attempting a self transfer to wheelchair after toileting. Resident #2 complained of left shoulder pain, describing that her/his shoulder hit the wall during the fall. As documented by progress notes on a date in October 2012, range of motion and vitals were assessed by Registered Nursing staff, pain medication was provided and the Resident was sent to hospital to assess possible fracture.

An Incident Report was completed indicating that Resident #2's range of motion and vitals were assessed by Registered Nursing staff, pain medication was provided, her/his Substitute Decision-maker was notified and that the Resident was sent to hospital. Report indicates that Resident #2 returned from hospital; shoulder and hip x-ray both negative. Report indicates the plan of action is that Resident #2 is to call for supervision when transferring.

A review of Resident #2's health care record indicates a risk of falls. Progress notes indicate two falls in October 2012 both related to Resident self transfers. Plan of care demonstrates a risk of falls related to medications, pain, impaired balance and coordination.

The health care record demonstrates that no clinically appropriate assessment instrument for post fall assessment was conducted related to the October 2012 falls.

Last post fall assessment for Resident #2 was conducted in July 2012, when resident fell while attempting to get out of bed on his own to go to the toilet.`

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. 131. Administration of drugs

Specifically failed to comply with the following subsections:

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).

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals;
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

The licensee failed to comply with O. Reg 79/10 s. 131(2) in that drugs were not administered to residents in accordance with the directions for use specified by the prescriber.

On a date in August 2012 Resident #3 was ordered a medication in patch form - two patches every morning. Resident #3's progress note nine days later in August 2012 indicates "resident telling staff members that her/his patches were put on late Friday...Patches were to go on at 06:00. staff member put them on at 10:00." November 14, 2012 discussion with staff member #S133 who wrote the progress note in August 2012 in which she indicated to the inspector that she "does not remember the incident, if I wrote it, it must be true."

On November 7, 2012 Resident #22 was ordered an antibiotic twice daily for 7 days. According to staff member # S101, the medication was delivered the evening of November 7, 2012 before 20:00 hours. At 06:30 on the morning of November 8, 2012 staff member #S101 found the unopened antibiotic bottle on the counter in the medication room. On November 13, at 14:00 discussion with Registered Pharmacy Technician at Classic Care Pharmacy who indicated to the inspector that Resident #22's antibiotics were delivered to the home on November 7, 2012 before 20:00 hours. The Medication Administration Record for resident #22 was reviewed for November 7, 2012. There is no documentation on November 7, 2012 to indicate that Resident #22 received the antibiotic which was ordered earlier in the day.

On November 13, 2012 @ 11:10 the inspector reviewed Resident #9's Medication Administration Record. There is no documentation that Resident # 9 received her/his 08:00 medications. On November 13, 2012 @ 11:20 staff member #S108 indicated to the inspector that due to competing priorities, she had not been able to administer the medications due at 08:00 this morning for Resident #9. On November 13, 2012 @ 11:11 staff member #S101 administered 08:00 medications to Resident #30.

November 15, 2012 @ 10:15: Resident # 45's Medication Administration record reviewed and the 08:00 medications for November 15, 2012 were not documented as administered. November 15, 2012 @ 10:20, discussion with Resident #45 who indicated that she/he had not received her/his 08:00 medications. November 15, 2012 @ 10:40 the inspector observed staff member #S101 administer the November 15, 2012, 08:00 medications to resident #45.

Resident #30 Medication Administration Record was reviewed. On October 12, 2012, the physician increased Resident #30's dose of a specific medication from three times per day to five times per day. The Medication Administration Record indicated that Resident #30 was to receive the five doses of this medication at 0600, 1000, 1400, 1800 and 2200 hours. On October 12, 2012, Resident #30's Medication Administration Record indicated that the resident received the specific medication at 0800, 1200, 1800, 2100 and 2200 hours. Staff member #S114 confirmed that this medication was administered at 1800, 2100 and 2200 hours on October 12, 2012. On November 1, 2012, the physician changed Resident #30's order for this specific medication to three times per day and her/his Medication Administration Record indicated that this medication was to be given at 0800, 1700 and 2100 hours. On November 4, 2012, it is documented in the progress notes that Resident #30 did not receive this medication at 1700 or 2200 hours because there was none of this medication to give. (124)

On November 14, 2012 at approximately 10:20, Resident # 47 was administered a specific medication. The Physician's Order indicates that Resident # 47 is to receive this medication before breakfast. Staff member # S112 stated that it is difficult to pass all the morning medications and the nurses try to priorize the administration of insulin to those residents requiring insulin in the morning. (126)

2. The licensee has failed to comply with O. Reg 79/10, s. 131. (4) in that a member of the registered nursing staff permitted a staff member who is not otherwise permitted to administer a topical without being trained by a member of the nursing in the administration of topicals and without the member of the nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical.

On November 20, 2012 discussion was held with staff member #S108 who indicated that the PSWs were to apply topical cream for Resident #42. The PSWs, however, reported that Resident #42 does not require topical cream because Resident's skin is intact at the present.

Discussion was held with staff members' #S106 and #S125 who both reported that they do apply topicals on a Resident

if required. They indicated that the registered nursing staff provides the PSW's with the topicals and instruct the PSW's on the application of the cream.

Staff member #S106 stated that she had a topical at the bedside of Resident #21 and further stated that she was unsure of what it is for and why it was at the Resident's bedside. The topical was white in color, was in a 30 ml plastic cup, and was not labelled with Resident's name, medication name, and application directions. Staff member #S106 indicated that she was unsure as to why the cream was at the Resident's bedside and a review of the Medication Administration Record was unable to demonstrate any indication of use.

Further discussion was held with several PSWs and all confirmed that PSWs who administered topicals do so without the supervision of a member of the registered nursing staff.

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. 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 :

The licensee failed to comply with O.Reg. 79/10, s.134(a) in that there was not monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Resident #30 had been prescribed a specific medication for pain three times per day since her/his admission in the summer of 2010.

On a date in October, 2012, Resident #30 complained of pain and received two doses of an analgesic, one of which was ineffective, as well as her/his regular doses of a specific medication. The following day (#2), Resident #30 received two doses of the analgesic for pain, again one of which was ineffective, in addition to her/his regular doses of a specific medication. On day #3 in October 2012, Resident #30's specific medication was increased from three times per day to five times per day.

There is no documented assessment of Resident #30's response to the increase in medication on day # 2 or #3 in October 2012.

Staff member #S101 reported to the inspector that after supper on a date in October 2012, Resident #30 was slow to respond and sleepy and she questioned that this may be related to the increased dose of the specific medication. Resident #30 had not had laboratory testing to determine her/his blood level of this medication since admission. On a date in October 2012, Resident #30 was sent to hospital and was diagnosed with a toxicity to the specific medication.

On a date in October 2012 Resident #30 was prescribed an analgesic every four hours as needed, to maximum of 4 grams/day. Between a latter date in October 2012 and fourteen days later, Resident #30 received nineteen doses of the analgesic and eight doses had no effectiveness documented.

On a date in November 2012, it is documented that Resident #30 is experiencing excruciating facial pain on the left side of her/his face.

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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

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 :

The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.6. (1) (b) in that the Resident's plan of care did not identify the goals the care is intended to achieve as evidenced by the following finding.

Resident #30 suffers from pain. The interventions in place to address Resident #30's pain include a specific medication three times per day and an analgesic four times per day.

On November 5, 2012 it was documented in the resident's progress notes that she/he was experiencing excruciating facial pain on the left side of her/his face.

On November 7 and 9, 2012, Resident #30 reported to the inspector that she/he was having pain on the left side of her/his face.

On November 14, 2012, Resident #30 reported to the inspector that her/his mouth and face were too sore to allow her/his to eat their supper.

Staff member #S125 and #S128 were interviewed by the inspector on November 15, 2012 and staff member #S125 reported that she/he was not aware Resident #30 was having facial pain. Staff member S#128 reported that it was several weeks ago that Resident #30 had complained of facial pain.

There was no written plan of care in Point Click Care that identified Resident #30's diagnosis or the goals of treatment.

2. The licensee failed to comply with LTCHA 2007, S.O., 2007, c.8, s. 6.(1)(c), in that the Resident's plan of care did not set out clear directions to staff and others who provide direct care to the Resident.

For meals, Resident #51 is seated in a wheelchair and restrained by a lap belt.

Resident #51's plan of care stated that a feeding restraint is used and well tolerated to allow Resident to stay seated and finish her/his meal.

During the supper meal on November 9, 2012, inspector #138 observed Resident #51 becoming agitated and pushing against the wheelchair. A Personal Support Worker intervened and staff later provided assistance with her/his meal.

During the supper meal on November 14, 2012, inspector #124 observed Resident #51 rocking against the restraint such that she/he moved the wheelchair which had brakes applied approximately four feet, on more than one occasion. Staff member #S139 returned the Resident to her/his table each time and was heard telling another/his PSW that she/he didn't know what to do. Staff member #S139 stated that if there was a staff member who could assist Resident #55 with her/his meal that her/his agitation would decrease. S#139 stated that she thought Resident #51 was hungry.

Resident #51's plan of care does not identify the Resident's agitation at meals and does not set out clear directions to staff in how to deal with this agitation.

Resident #42 exhibited altered skin integrity in October 2012. The plan of care does not set out clear directions for altered skin integrity for nursing staff who provide treatment. PSW are applying topical cream without training/education on product used. Registered nursing staff did not complete skin assessment to monitor the condition of the skin and did not document in Resident health record any response to treatment. (126)

3. The licensee failed to comply with LTCHA 2007, S.O., 2007, c.8, s. 6. (4) (a) in that the licensee has not ensured that the staff and others involved in the different aspects of care of the Resident collaborate with each other in the assessment of the Resident so that their assessments are integrated and are consistent with and complement each other/his.

Resident #38 was observed during the first dining observation of the inspection on November 5, 2012 not eating or drinking. Staff member #S101 stated that the Resident had a recent urinary tract infection with antibiotic therapy and that the Resident had not been eating or drinking well since the previous Friday (November 2, 2012). Resident #38 was

observed again on November 8, 2012 at breakfast and ate little and had less than one half of a mug of coffee. On November 9, 2012 Resident #38 was observed at lunch again to not eat and only consumed sips of coffee. It was also noted that the Resident consumed very little food and fluids at snack time as well. Discussion was held with the Registered Dietitian the evening of November 9, 2012 and she/he confirmed that she/he had not been communicated to regarding changes in Resident #38's health condition and therefore had not assessed the Resident. The Resident's weight was measured the following week on November 13, 2012 and it was noted that the Resident experienced significant weight loss.

Resident #30 is experiencing facial pain and decreased food intake at meals times as observed on November 8 and 9, 2012. This Resident is assessed at high nutritional risk and is exhibiting an undesirable pattern of weight loss. The home's Registered Dietitian confirmed that she was not made aware of issues with Resident's health condition and further reported that she is often not made aware of concerns with Residents until a Resident has exhibited weight loss which gets identified by her through the monthly weights.

Resident #25 was observed at lunch on November 9, 2012 to eat very little and only take sips of thickened water. The Resident was observed again at supper that same day and evening staff member assisting the Resident reported that she was unaware that the Resident had poor food and fluid intake at lunch. This Resident has exhibited a gradual, undesirable history of weight loss and is assessed to be high nutritional risk.

Further discussion was held with the staff member #S111 regarding the communication of Residents' nutritional concerns, such as Resident #25, among nursing staff. Staff member #S111 stated that the 24 hour report binder is used to communicate information from shift to shift but that the contents of the 24 hour report are dependent on communication from the PSWs to the registered staff and she further stated that often times information is missed. The 24 report binder was reviewed for the period of November 5 – 9, 2012 and no Resident nutritional concerns were documented including concerns regarding Resident #25.

4. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6(7) to ensure that care set out in the plan of care is provided to the Resident as specified in the plan.

On a date in May 2012 the home submitted a report via the Critical Incident system regarding an incident that occurred the previous day. Resident #35 had fallen from her/his bed, sustained injuries and was sent to hospital. According to the report, the Resident #35's posey alarm was attached to the bed and was not attached to the Resident's gown.

Resident #35's care plan of February 14, 2012 was reviewed. It indicates that the posey alarm is to be attached to the Resident while in bed.

On November 14, 2012 Registered Nursing staff member # S100 indicated to the inspector that when she entered Resident #35's room to attend to the Resident's injuries, she observed that the posey alarm was not attached to the Resident.

On November 14, 2012 the Administrator/Director of Care of the home indicated to the inspector that she had conducted an investigation of the incident in May 2012 and discovered that the Personal Support Worker had not reattached the posey alarm to the Resident after the provision of care. The Personal Support worker was re-instructed. [Log #O-01174-12]

5. On November 9, 2012, the physician ordered that Resident #22 was to "elevate right lower leg at all times except when up to bathroom or meals". On November 14 and 15, 2012, Resident #22 was observed to be sitting in her/his wheel chair in the morning without her/his right lower leg elevated.

Additional Required Actions:

CO # - 005, 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: 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 subsections:

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).

Findings/Faits saillants :

The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 3 (1) 1. in that every Resident has not had 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.

On November 8, 2012 at breakfast Resident # 38 was provided regular milk by a staff member in her/his cereal when the Resident's care plan directs staff to provide lacteeze milk due to a lactose intolerance.

On November 9, 2012 at lunch Resident #35 was provided a meal of buttered cabbage, boiled potato, and corned beef brisket while her/his care plan stated that the Resident has a dislike to cabbage. The Resident did not eat the cabbage and no other/his alternative vegetable was offered.

Resident #25 is known by staff members to enjoy fruit and vegetables and is care planned to receive double portions of vegetables at meals. It was observed on two supper meal observations, November 9 and 13, 2012 that the Resident did not receive double portions of vegetables as planned. (138 and 148)

Resident #25 and Resident #35 are care planned to use a nosey cup to assist in receiving fluids. It was observed at lunch on November 9, 2012 that Resident #25 did not have a nosey cup when drinking fluids and it was observed that Resident #35 also did not have a nosey cup for fluids at any of the four meals observed.

The East tubroom was observed to have a window approximately five feet from the floor and is next to the Residents' tub. The window looks out to the high school sports field that is adjacent to the home and students have been observed to be in the field over the course of the inspection. There is no ability to afford privacy to Residents who may be bathing from the window, particularly those Residents who are required to be lifted using the tub chair lift.

Resident #34 was reported by staff member #S108 to have a condition of overactive sebaceous glands that causes build -up of skin and requires specific washing techniques to remove the skin build up. Staff member #S108 stated that PSWs are not washing the Resident correctly to remove the skin build up and that PSWs require further training to manage Resident's skin condition.

2. On November 13, 2012, Staff member #S107 was observed assisting Resident #32 with breakfast. Staff member #S107 used the Resident's shirt protector to wipe her/his mouth on more than one occasion. Residents are provided with a napkin for wiping their mouths during meals.

On November 14, 2012 around 1700 hours, Resident #44 was seated in her/his wheelchair at the dining room table. Resident #44 was wearing split back clothing and her/his lower back and top of buttocks were exposed between the lower edge of the back of her/his wheelchair and the top of wheel chair seat. The back of Resident #44's incontinent brief was showing, as well as approximately six inches of the outer part of her/his right thigh. This was brought to the attention of Staff member #S120 who adjusted Resident #44's clothing so that she/he was no longer exposed.

On November 9, 2012, Staff member #S111 was observed administering insulin to Resident #31 in the hallway outside the dining room. On November 19, 2012, Resident #31 was interviewed by the inspector. Resident #31 reported that she/he did not remember receiving her/his insulin in the hallway on November 9, 2012 and stated that she did not like getting her/his insulin in the hallway because it is not private enough:

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 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, 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 subsections:

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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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 :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.15(2)(a) to ensure that equipment is kept clean.

On November 7, 2012 in the east tub room, the inspector observed the mechanical lift tub seat with white sediment on the back of the seat. (138)

The arms of the white couch in the family room has brownish colored stains as well as one cushioned seat.(126)

On November 8, 9, 20, 2012 the inspector observed dust and dried debris on the following Resident's equipment: Wheelchairs belonging to Residents #7, #18, #21, #22, #25, #40, #43, #44 and walkers belonging to Residents # 19, #37.

2. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.15(2)(c) to ensure that the home is maintained in a good state of repair.

Throughout this inspection it was observed by the inspectors that the wooden handrails in the main corridor are missing finish, the door frames around the entrance to Resident rooms are missing paint, and the dining room table legs are scuffed and missing finish. On the west wall of room 4 there is a horizontal line of unpainted plaster approximately 5 feet up from the floor, window all damage and the door of the bathroom has unpainted plaster patching near the right lower edge of the wall adjacent to the bathroom entrance. In room 7 the door to the bathroom is missing paint and the curtain rod is bent.

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 equipment is kept clean, to be implemented voluntarily.

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

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O., 2007, c.8, s.76(2)10, in that the licensee did not provide for training related to policies relevant to the person's responsibilities.

Interview of two newly hired staff members, #S129 and #S136, on November 20, 2012 stated that they had not received training on any policies relevant to performing their duties, outside of what was provided in the General Orientation.

Administrator confirmed, through interview on November 20, 2012, that training related to policies specific to a person's responsibilities were not included in the General Orientation and that training on such policies was not provided prior to staff members performing their responsibilities.

2. The licensee has failed to comply with LTCHA 2007, S.O., 2007, c.8, s.76(2) 8., in that the licensee did not provide for training related to emergency and evacuation procedures.

A review of the home's General Orientation for November 12, 2012, demonstrates that training on emergency and evacuation procedures was not provided to staff members. Administrator confirmed, through interview on November 20, 2012, that emergency and evacuation procedures were not included in the General Orientation and that such training was not provided prior to staff members performing their responsibilities.

3. The licensee has failed to comply with LTCHA 2007, S.O., 2007, c.8, s.76(2) 4., in that the licensee did not provide for training related to mandatory reports under section 24.

A review of the home's General Orientation for November 12, 2012, demonstrates that training on the duty to make mandatory reports under section 24 was not provided to staff members. Administrator confirmed, through interview on November 20, 2012, that the duty to report was not included in the General Orientation and that such training was not provided prior to staff members performing their responsibilities.

4. The licensee has failed to comply with LTCHA 2007, S.O., 2007, c.8, s.76 (2) (1-9), in that two staff members did not receive training prior to performing their duties, as provided for in this regulation.

Newly hired staff members #S137 and #S138, began performing their duties in direct Resident care beginning on October 13 and 14, 2012. Training, on items under LTCHA 2007, S.O., 2007, c.8, s.76 (2), was not provided prior to the two staff members performing their duties. The two staff members were provided with the home's General Orientation on November 12, 2012.

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 person performs their responsibilities before receiving training as provided for in O. Reg 79/10, s.76(2), to be implemented voluntarily.

WN #9: 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 subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to comply with O.Reg. 79/10, s. 8. (1)(b) in that the home has not complied with their Fall Policy, part of the Fall Prevention and Management Program as required by O. Reg. 48. (1) 1.

O.Reg. 79/10 s. 48 (1) 1., provides that every home shall have a Falls Prevention and Management Program to reduce the incidence of falls and the risk of injury. A component of the home's Falls Prevention and Management Program is the home's Fall Policy (#09-02-11) updated November 2011 that directs registered staff members to complete a Post Fall Analysis Report when a Resident has a fall.

The plan of care of Resident #2 demonstrates the Resident's risk of falls related to medications, pain, impaired balance and coordination. Progress notes in the Resident health care record for Resident #2 indicate that the Resident had three falls in October 2012, related to Resident self transferring. The health care record further demonstrated that registered staff did not complete the Post Fall Analysis Report, as per the home's policy, in relation to the falls that occurred in October 2012. (148)

On a date in September 2012, it was documented in the progress notes in the Resident health care record that Resident #27 also had a fall. The progress notes indicated that the Resident was trying to get up from bed and slipped to the floor. The health care record again further demonstrated that registered staff did not complete the Post Fall Analysis Report, as per the home's policy, in relation to the fall that occurred on a date in September 2012.

The home's Fall Policy further stated that registered nursing staff are responsible for ongoing assessment of the Resident for 24 hours after a fall and that all assessments and actions during the 24 hour post fall follow up are to be documented in the progress notes. Resident #27 sustained a fall on on a date in September 2012 and the next progress entry is dated October 13, 2012 and described an incident of incontinence. (124)

The home's Fall Policy, with respect to unwitnessed falls, also indicated that registered nursing staff will initiate a neurological assessment monitoring routine at recommended intervals for 24 hours post fall for signs of neurological changes. These recommended intervals include every 15 minutes for one hour, every hour for four hours and every four hours until 24 hours has elapsed.

On a date in November 2012, Resident #37 was found sitting on the floor at the side of her/his bed. A neurological assessment was immediately initiated. Resident #37's Neurological Flow Chart for two subsequent dates in November 2012 was reviewed. Resident #37 was to have neurological assessments on a date in November 2012 at 23:45 and the following day in November 2012 at 03:45.

There is no documentation to indicate that Resident #37's neurological assessments were conducted on a date in November 2012 at 23:45 and the following day in November 2012 at 03:45. It is written on the Neurological Flow sheet that the Resident was sleeping at those times.

On a date in September 2012, it is documented in the progress notes that Resident #27 was trying to get up from bed and slipped to the floor. The home's Fall Policy stated that after a fall, a Post-Fall Analysis Report will be completed.

There was no Post-Fall Analysis Report completed for Resident #27's fall on the date in September 2012.

2. The licensee failed to comply with O.Reg 79/10, s.8(1)(b), in that Residents were not able to make withdrawals from their trust account or petty cash trust as stated in the home's policy.

O. Reg. 79/10 s. 241(5) (b), provides that the licensee shall have a written policy that includes when a Resident can make withdrawals from a trust account and petty cash trust.

A review of the policy titled "Trust Fund Accounts" Number 00-00-00 dated January 2011, indicates that a Resident can make deposits to or withdrawals from the petty cash trust money are 8 am to 4 pm, Monday to Friday.

Interview of Office Manager on November 16, 2012 confirmed that access to trust accounts and petty cash trust are 8 am to 4pm, Monday to Friday. The Office Manager #S104 stated that she is the only staff member with access to funds

and that as of November 15, 2012, there are no other staff members trained to access funds.

On November 15, 2012 at 1410 hours, Inspector #161 observed the Activity manager who came to the front office and requested 75 cents on behalf of Resident #48's trust account to enable resident to play bingo. The Office Manager #S104 was not in the home and Office Manger #S124 did not have access to the trust account funds. It was determined that no staff member in the home had access to the funds for the afternoon of November 15, 2012.

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's policies related to falls and trust accounts are complied with, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

The licensee has failed to comply with O. Reg 79/10 s.107.(3) in that the home did not inform the Director no later than one business day after the occurrence of an injury in respect of which a person is taken to the hospital.

On a date in October 2012, Resident #22 fell and was sent to hospital for an assessment. The Director was informed 9 days after the occurrence of the incident.

Resident #2 was found on the floor of bathroom on a date in October 2012 at 2230 hours after attempting a self transfer to wheelchair after toileting.

Resident #2 complained of left shoulder pain, describing that her/his shoulder hit the wall during the fall. As documented by progress notes on a date in October 2012, range of motion and vitals were assessed by Registered Nursing staff, pain medication was provided and the resident was sent to hospital to assess possible fracture.

A review of the Critical Incident System demonstrates that the home has not informed Director of the injury that resulted in hospital transfer on a date in October 2012.

Interview with the Administrator/Director of Care on November 15, 2012, confirms that this incident has not been reported to the Director. (148)

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 the home informs the Director related to incidents as per O. Reg 79/10, s.107 (3), to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

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
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s. 129(1)(b) in that the licensee did not ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area.

On November 8, 2012 during inspection of the medication room, one vial of Lorazepam 4mg/ml was observed to be stored in a small black metal box which was unlocked in the refrigerator in the medication room. On November 16, 2012 the inspector showed the Administrator/Director of Care the unlocked vial labelled Lorazepam 4mg/ml which the Administrator/Director of Care subsequently removed from the refrigerator in the medication room (161)

2. On November 13, 2012, during inspection of the medication room, five vials of Diazepam 10mg/2ml injectable medication were observed to be stored in a small white cupboard which was unlocked and the key was in the lock.
3. The licensee failed to comply with O.Reg. 79/10. s. 129. (1) (a) in that drugs were not stored in an area or medication cart that is used exclusively for drugs and drug related supplies.

On November 13, 2012,on the shelf above the computer which contained medications, the following items were noted:

- a "Studio" calculator, a "Mighty Sonic" Safety horn, a bottle of No Rinse Body Wash, Shampoo and Incontinent Cleanser, a box of Future Med Sterile Combine pads, a small blue container with handles, a 11/2 inch tensor bandage, a box of Tie-On Surgical Masks, Box of Smith and Nephew Skin Prep,a ziploc bag with gloves and Ombrelle 60SPF sunscreen.

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 controlled substances are stored in a separate, double-locked stationary cupboard in the locked area and that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

Resident #30 received a specific medication to treat her/his pain.

On a date in November 2012, the physician changed Resident #30's order for a specific medication to three times per day and her/his Medication Administration Record indicated that the medication was to be given at 0800, 1700 and 2100 hours.

Three days later in November 2012, it is documented in the progress notes that Resident #30 did not receive a specific medication at 1700 or 2200 hours because there was none of the medication to give.

The Administrator/Director of Care reported to the inspector that she considered Resident #30's missed doses of the specific medication to be an omission of medication and omissions constituted drug errors.

The Administrator/Director of Care reported to the inspector that she was not aware that Resident #30 had missed doses of the specific medication on a date in November 2012 and that she had not received a medication incident report for the omissions.

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 that every medication incident involving a Resident is documented, together with a record of the immediate actions and reported to the Director of Nursing and Personal Care, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following subsections:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

The licensee failed to comply with O. Reg. 79/10, s.52. (2) in that a Resident's pain was not relieved by initial interventions and the Resident was not assessed using a clinically appropriate assessment instrument specifically designated for this purpose.

Resident #30 has pain and was prescribed a specific medication three times per day and an analgesic as needed.

On a date in October 2012, Resident #30 complained of pain in her/his cheek. She/he received two doses of an the analgesic the following day (#2) in October and on the subsequent day (#3) in October 2012 she/he received another two doses of the analgesic. Two of the four doses of the analgesic were ineffective in addressing Resident #30's facial pain.

Staff member #S100 reported to the inspector that when a Resident's pain medication is ineffective, a pain assessment flow sheet is completed for three days.

There were no pain assessment flow sheets completed during this time for Resident #30 or no pain assessments completed in Point Click Care.

There is no clinical documentation to indicate that the Resident's pain was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident is assessed using a clinically appropriate assessment instrument when the Resident's pain is not relieved by initial interventions, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 53. (1) 1. in that written approaches to care have not been developed to meet the needs of Residents with responsive behaviours that include screening protocols, assessment and identification of behavioural triggers.

On November 19, 2012, the Administrator/Director of Care reported that the home does not have a program established to deal with responsive behaviours. There are no policies and procedures, no assessment protocols and no referral processes established.

The Administrator/Director of Care stated that referrals have been made to Behavioural Support Ontario and psycho-geriatric outreach team.

2. The licensee has failed to comply with O.Reg 79/10 s.53.(4)(a) in that the home did not identify behavioural triggers for two Residents demonstrating responsive behaviors.

Resident #22 has been exhibiting agitated behaviors mostly in the evening around supper time for the past several months. On November 14, 2012 , Inspector #124 observed Resident #22 becoming increasingly agitated after supper, wanting to go to the bathroom. After an attempt by 3 staff members to bring Resident #22 to the bathroom, she/he was left in the hallway. Resident #22 continuing to be agitated, kicking the charts racks and the gate at the nursing station. The Regional Director requested that staff make another attempt to bring the Resident to the bathroom. Resident #22 was brought to the bathroom and then was put to bed. No further behavior observed.

Agitation caused by the need to go to the bathroom was not identified by staff as a behavioural trigger in Resident # 22's plan of care.

3. During the supper meal on November 9, 2012, inspector #138 observed Resident #51 becoming agitated and pushing against the wheelchair.

During the supper meal on November 14, 2012, inspector #124 observed Resident #51 rocking against the restraint such that she/he moved the wheelchair which had brakes applied approximately four feet, on more than one occasion.

Staff member #S134 reported to the inspector that Resident #51 is more agitated in the dining room lately and Staff member #S106 added that Resident #51 is agitated at almost every meal.

Agitation while restrained at meal time has not been identified as a behavioural trigger in Resident #55's plan of care.

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 written approaches to care are developed to meet the needs of Residents with responsive behaviours that include screening protocols, assessment and identification of behavioural triggers, to be implemented voluntarily.

WN #15: 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 subsections:

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
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, s. 37 (1)(a) in that the licensee of the long term care home did not ensure that each Resident of the home has his or her personal items labelled within 48 hours of admission and of acquiring, in the case of new items.

Resident #39 shares a washroom with another Resident(s). In the washroom on November 6, 2012 there was an unlabelled hair comb, unlabelled used bar of soap, an unlabelled blue basin containing unlabelled toothpaste and an unlabelled toothbrush. The next day on November 7, there was an unlabelled and used bedpan sitting on the tank of the toilet in the same washroom.

In the East tub room on the morning of November 7, 2012 it was noted that on the shelving there was an unlabeled pink round plastic container that held two unlabeled bars of used soap and two unlabeled used hair brushes. There was also a cardboard box with three unlabelled hairclips and an unlabelled used bar of soap. There was a third unlabelled container containing one pair of nail clippers with hair clips. A return to the East tub room after lunch demonstrated the same items were present plus a used razor.

WN #16: 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 subsections:

s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;
(c) that the local medical officer of health is invited to the meetings;
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(e) that a written record is kept relating to each evaluation under clause (d) 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. 229 (2).

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. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

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.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
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.
5. There must be a staff immunization program 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 has failed to comply with O. Reg 79/10, s. 229. (2)(b) in that the interdisciplinary team that coordinates and implements the Infection Prevention and Control Program does not exist and has not met quarterly.

The Infection Control Practioner (ICP) was interviewed on November 15, 2012, and she stated that there was no Infection Prevention and Control Program interdisciplinary team in the home at this time. The ICP further reported that the home will be implementing the Extendicare Infection and Prevention Control Program in the near future.

The last Infection Prevention and Control Program interdisciplinary meeting was last year in October 2011.(126)

The licensee has failed to comply with O. Reg 79/10, s. 229. (4) in that not all staff participate in the implementation of the Infection Prevention and Control Program.

During the lunch meal on November 5, 2012, a health care aide responsible for feeding Resident #32 was observed to spoon the Resident's food, then blow on the food and touch the food on her wrist.(148)

In the East tub room on the morning of November 7, 2012 it was noted that on the shelving there was an unlabelled container containing one pair of nail clippers. A return to the East tub room after lunch demonstrated that the nail clippers were still present. Staff member #125 was asked about the nail clippers in the East tub room and she stated that the nail clippers were purchased by a staff member for Resident use and further explained that they should not be there as staff carry their own nail clippers that are disinfected between use. She was unable confirm disinfection practices for the nail clippers left in the tub room. (138)

A staff member #S109 stated that the home does not provide Resident nail clippers and that staff are responsible to provide their own nail clippers for Resident use. Staff member #S109 further stated that she sprays her nail clippers with the disinfectant used to clean the tub and them rinses them in the sink with hot water. She reported that she is unaware of any home policy or home practice to clean nail clippers. (138)

A staff member #S121 also confirmed that the home expects the staff to purchase their own nail clippers to provide nail care to Residents. She stated that she was not aware of any home policy and procedure to clean nail clippers but further stated that she cleans her nail clippers with soap and water. She further stated that she was going to use hand sanitizer to clean the nail clippers but was told that hand sanitizer only works on hands and not objects. (138)

An interview was conducted with the ICP on November 15, 2012 and she stated that the home does not have an Infection Prevention and Control Program implemented at this time. The ICP further reported that she was recently provided the Extendicare Infection Prevention Control Program on November 13, 2012 and that the home is working on implementing the program in the near future. (126)

On November 6, 2012, staff member #S101 was observed touching the right foot of Resident #22 and after the assessment she was observed to walk to the medication cart and continue passing the medications. No hand hygiene was observed between assessment and administration of the medications. (126)

During observation of the supper meal on November 14, 2012, Resident #11 dropped some food on the floor, and was attempting to retrieve the food with her/his fork. Before Resident #11 fell trying to get it, the inspector requested that staff member #S120 assist the Resident. Staff member #120 used her hand to retrieve the food from the floor and dropped it in garbage. Staff member #S120 did not wash her hands before she returned to assist Resident #25 with her/his dinner.

It was observed through the course of several meal observations that a student #S135 and several PSWs did not consistently perform hand hygiene between assisting Resident and handling soiled dishes and linens/napkins. (138)

Discussion with several PSW though out the inspection and all stated that they were unable to recall their last training on hand hygiene. New staff are provided education on hand hygiene as part of the four hours general orientation. (126)

The licensee has failed to comply with O. Reg 79/10, s. 229. (10)1 in that each Resident admitted to the home was not screened for tuberculosis within 14 days of admission.

The following Residents were not screened for tuberculosis within 14 days of admission:

Resident #53 was admitted on August 13, 2012. The Resident's health care record was reviewed with staff member #S100 and she confirmed that there was no supporting documentation to demonstrate that the Resident was screened for tuberculosis.

Resident # 22 was admitted on April 14, 2011. Resident health care record reviewed with staff member #S100 and she confirmed that there was no supporting documentation to demonstrate that the Resident was screened for tuberculosis.

Resident #50 was admitted on August 1, 2012 and was screened for tuberculosis Step 1 Mantoux on September 24, 2012, 54 days after admission.

Resident #43 was admitted on August 9, 2012 and was screened for tuberculosis Step 1 Mantoux on September 25, 2012, 45 days after admission.

Resident #47 was admitted July 19, 2012 and was screened for tuberculosis on September 21, 2012, 64 days after admission. (126)

The licensee has failed to comply with O. Reg 79/10, s. 229. (10)3. in that the home did not offered immunization against tetanus and diphtheria in accordance with the publicly funded immunization schedule posted on the Ministry website.

Discussion was held with ICP on November 15, 2012, and she indicated that Residents are not offered immunizations against tetanus and diphtheria at the present time but immunizations will be implemented in the near future.(126)

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 an interdisciplinary infection, prevention and control team and that all staff participate in the implementation of the program, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The license failed to comply with O.Reg 79/10, s. 50. (2) (b) (iv) in that a Resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is not assessed at least weekly by a member of the registered nursing staff, if clinically appropriate.

Resident #24 was documented as per MDS Care Plan on a date in November 2012 to have two stage II ulcers in the coccyx area. Staff member #S108 stated that she was unsure of the current status of the Resident's stage II ulcers and referred inspector to the health record for assessments. The Resident's care provider, staff member #122, confirmed that the Resident does not currently have ulcers in the coccyx area. The Resident's health record was reviewed and the last available assessment regarding the Resident's skin ulcers in the coccyx area was written on a date in September 2012. The chart was then again reviewed with the home's RAI Coordinator and he confirmed that the last skin assessment was conducted on the date in September 2012. There were no further progress notes after the last MDS Care Plan mentioned above written on a date in November 2012 that indicated any further assessment regarding the Resident's identified stage II ulcers.

Minimum Data Set (MDS) Assessment written on a date in September 2012 indicates that Resident #2 had a Stage 2 ulcer on her/his left ankle. Weekly Skin and Mouth Observation sheet completed by Health Care Aid on a date in October 2012, indicates that ankles are open.

Interview of Staff member #S101 responsible for the care of Resident #2 on a date in November 2012, confirmed that the left ankle wound has been open since a date in September 2012, but was unable to confirm status of the wound prior to this date. Staff S#101 was not able to confirm when the right ankle wound opened, but suspects the wound opened on a date in November 2012 based on the treatment orders. Staff #S101 stated that the skin integrity of both ankles has been an ongoing issue.

Interview of Staff member #S100 on November 15, 2012, stated that weekly assessments by registered nursing staff would be expected to be completed on open wounds and that such assessments are completed in the Weekly Wound Care Report on Point Click Care.

A review Resident #2's health care record and confirmation by Staff member #S100 and #S101, demonstrates that the only weekly assessment completed by a member of the registered nursing staff was on a date in November 2012. (148)

2. The licensee had failed to comply with O.Reg s.50.(2)(b)(i) in that the Resident exhibiting redness under right breast fold does not receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

At the end of October 2012, Resident #42 exhibited altered skin integrity and was prescribed a topical cream. The topical cream was applied by the PSW on a daily basis.

Resident #42 health care record was reviewed and no documentation was found related to the assessment or monitoring of the altered skin integrity.

Registered nursing staff interviewed and they indicated that they do not always do the weekly skin assessment on Residents and they do not use a clinically appropriate assessment instrument.

3. The licensee has failed to comply with O.Reg 79/10, s.50 (2)(b)(iii), in that a Resident exhibiting altered skin integrity has not been assessed by a registered dietician.

A review of Resident #2's health care record and interview of registered nursing staff #S101, responsible for care demonstrates that this Resident has had a Stage 2 ulcer on her/his left ankle since a date in September 2012 and a Stage 2 ulcer on right ankle since a date in November 2012.

A review of Resident #2's health care record demonstrates that the home's registered dietician has not completed an assessment of the Resident's current skin integrity issues.

Interview with the home's Registered Dietician on November 20, 2012, stated that she was unaware of Resident #2's Stage 2 ulcer.

4. Minimum Data Set (MDS) Assessment dated September 14, 2012 indicates that Resident #2 had a Stage 2 ulcer on left ankle. Weekly Skin and Mouth Observation sheet completed by Health Care Aid on October 23, 2012, indicates that ankles are open.

Interview of Staff member #S101 responsible for the care of Resident #2 on November 19, 2012, confirmed that the left ankle wound has been open since September 14, 2012, but was unable to confirm status of the wound prior to this date. Staff S#101 was not able to confirm when the right ankle wound opened, but suspects the wound opened November 8, 2012 based on the treatment orders. Staff #S101 stated that the skin integrity of both ankles has been an ongoing issue.

Interview of Staff member #S100 on November 15, 2012, stated that weekly assessments by registered nursing staff would be expected to be completed on open wounds and that such assessments are completed in the Weekly Wound Care Report on Point Click Care.

A review Resident #2's health care record and confirmation by Staff member #S100 and #S101, demonstrates that the only weekly assessment completed by a member of the registered nursing staff was on November 11, 2012. (148)

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information

Specifically failed to comply with the following subsections:

s. 225. (1) For the purposes of clause 79 (3) (q) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 79 of the Act includes the following:
1. The fundamental principle set out in section 1 of the Act.
2. The home's licence or approval, including any conditions or amendments, other than conditions that are imposed under the regulations or the conditions under subsection 101 (3) of the Act.
3. The most recent audited report provided for in clause 243 (1) (a).
4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service.
5. Together with the explanation required under clause 79 (3) (d) of the Act, the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act. O. Reg. 79/10, s. 225 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s. 225(1)3 in that the most recent audited report was not posted in the home.

A tour of the home noted that the most recent audited report was not posted. This was confirmed by the home's Office Manager.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following subsections:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any;
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10, s. 27. (1) (a) in that the Resident did not have a care conference of the interdisciplinary team to discuss the plan of care and any other matters of importance to the Resident or her/his substitute decision-maker at least annually.

Resident #30 was admitted to the home in August 2010. The care conference report of August 2011 indicates that Resident #30's substitute decision-maker was in attendance. On a date in November 2012, Resident #30's substitute decision-maker reported to the inspector that there has not been a care conference since August 2011. The following day in November 2012, Resident #30 's substitute decision-maker reported to the inspector that she had come to the home expecting a care conference and had met with the Resident's physician. The substitute decision-maker reported that no other members of the care team were present.

The Administrator/Director of Care reported to the inspector that she would expect the annual care conference to be an interdisciplinary conference, including the nurse, activity staff, dietician/dietary supervisor, physiotherapist and the pharmacist and/or physician if in the building.

Resident #22 was admitted to the home in April 2011 and the interdisciplinary team did not have a care conference in 2012. Discussion with Resident # 22's substitute decision-maker who stated that she recently received a letter and was invited to a care conference to be held in February 2013.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s.32 in that a Resident did not receive individualized personal care, including hygiene and grooming on a daily basis.

Resident #22 is a diabetic and requires special foot care. On a date in November 2012 Resident #22 was observed to have facial hair on her/his chin and long toe nails, approximately 2 centimeters long, on her/his right foot. Resident's Substitute Decision-maker stated to the inspector that she/he has never had a discussion with the home regarding foot care for diabetic Residents. Staff member S#101 indicated to the inspector that she will leave a note for the foot care nurse.

On a date in November 2012 Resident #22 was observed to have dirty fingernails with red and black debris under them.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following subsections:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures;
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to comply with s. 34.(1)(c) to ensure that Residents are offered an annual dental assessment and other preventive dental services.

Resident #31's progress note on a date in October 2012 was reviewed. It indicates "daughter/son in the am. States mother/father has been complaining to her/him of sore tooth. Lower right tooth noted to be decaying and wishes it to be addressed." Explained that families usually take care of dental appointments and she/he is going to look into having a hygienist come in and assess the tooth first and get back to us."

November 20, 2012 discussion with staff member #S101 who indicated to the inspector that if a Resident requires a dentist, it is the family who will arrange an appointment at the dentist's office for the Resident.

On November 9, 2012 the Administrator/Director of Care indicated to the inspector that at the current time, the home does not offer an annual dental assessment and other preventive dental services for Residents. The Administrator/Director of Care will explore in-home dental service providers.

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 130(1) in that the drugs were not stored and kept locked at all time when not in use.

On November 5, 2012, around 09:30 it was observed by the inspector that a medication cart was left unattended and unlocked in the front entrance hallway. No registered nurse was in close proximity of the medication cart. Several minutes passed before Staff member #S101 came out of the dinning room and returned to the medication cart.

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following subsections:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;
(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to comply with s. 90(2) (a) to ensure that all devices in the home are kept in good repair.

On May 10, 2012 the home submitted a report via the Critical Incident system regarding an incident that occurred on a date earlier in May 2012. Resident #35 had fallen from her/his bed, sustained injuries and was sent to hospital. She/he had a posey alarm device in place.

On November 14, 2012 the Administrator/Director of Care of the home indicated to the inspector that she had conducted an investigation of the incident on a date in May 2012 involving resident #35 and discovered that the batteries in the posey alarm device were not working.[Log #O-002109-12]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

The licensee failed to comply with O. Reg 79/10, s. 68. (2) (d) in that the system does not allow monitoring or evaluation of the food and fluid intake of Residents identified at risks related to nutrition and hydration.

The Registered Dietitian stated that the PSWs are responsible for documenting Resident intake on the food and fluid intake record and the registered nursing staff on nights are responsible nightly to review the food and fluid intake records of the Residents. The registered nursing staff are to initial the records and communicate any concerns to the appropriate individuals. The Food Service Supervisor confirmed that this was the expected practice in the home, that she provides orientation on this practice for new hires, and that she recently sent a communication memo dated October 17, 2012 to registered nursing staff reminding them that it was their responsibly to review the food and fluid intake records and to send a dietary referral where appropriate.

The Registered Dietitian and Food Service Supervisor confirmed that food and fluid intake records are not being reviewed and that they are not consistently receiving referrals regarding Residents' food and fluid intake and specifically confirmed that referrals were not received for Resident #25, #38, and #39 who are Residents at high nutritional risk and exhibited recent decreased food and/or fluid intake.

The food and fluid intake records were reviewed from November 1 – 12, 2012 for Residents #25, #30, #34, #38, and #46, all of which are assessed to be at high nutritional risk. It was noted that all food and fluid intake records reviewed were incomplete in that food and fluid intake was not consistently documented for meals and snacks.

When documentation of Residents' food and fluid did occur, it was observed that the documentation did not always accurately reflect the intake of several Residents identified at high nutritional risk and that Residents' actual intake was overestimated. The home's Registered Dietitian confirmed that the practice of overestimating Residents' food and fluid intake on the food and fluid intake records would make it difficult for any staff member, including her, to identify nutritional concerns through a review of the records.

The following inaccuracies in food and fluid documentation were observed:

Resident #22 was observed on November 9, 2012 to refuse her/his supper and not take any fluids. Her/his food intake was accurately documented but fluid intake was documented as 1 – 6oz fluid.
Resident #25 at lunch on November 8, 2012 ate dessert and sips of water but was documented to consume ¼ of meal and 1 – 6oz fluid.
Resident #38 was observed at lunch on November 9, 2012 to drink only ½ - 6oz fluids but was documented to consume 2 – 6 oz fluids.
At supper that same day Resident #38 was observed to eat only bites of dessert and sips of fluids but was documented to consume ¼ of meal and 1 – 6 oz fluid.

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

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:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and
(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 :

The licensee failed to comply with O.Reg. 79/10, s. 73. (1) (9) in that the licensee failed to provide all Residents with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

It was observed over the course of several dining services that not all Residents were provided with encouragement and assistance to eat and drink their meals and fluids. Resident #39 was observed to be asleep at the dining room table when her/his breakfast meal was brought to her/him on Thursday November 8, 2012. She/he was not woken or provided encouragement when her/his meal was delivered to her/him and continued to sleep for ten more minutes with her/his meal in front of her/him before she/he was woken by a PSW. Once awoken staff did not provide further encouragement to the Resident to eat or drink and this Resident left the dining room without consuming her/his breakfast including her/his prescribe nutritional supplement and her/his fluids. This Resident is assessed to be at a high nutritional risk.

Resident #46 was observed to fall asleep while eating her/his meal at supper on Friday November 9, 2012. The Resident continued to sleep throughout the meal for at least twenty minutes and no encouragement or assistance was provided to the Resident to finish her/his meal. The Resident was observed to eat less than 25% or her/his meal. This Resident is assessed to be a high nutritional risk

Resident #25, who requires complete feeding assistance, was observed not eating any of her/his lunch meal. Staff member #S110 feeding the Resident did not make any further attempts to encourage intake including offering food items that Resident is known to enjoy. This Resident is assessed at high nutritional risk.

Resident #30 was observed to refuse her/his supper the evening of November 9, 2012 and November 13, 2012. Staff were observed both times to take away the entrée without further encouragement and did not offer alternatives to encourage or promote intake. This Resident is assessed to be at high nutritional risk and is currently exhibiting an undesirable pattern or weight loss. (138 and 148)

Resident #32 requires total assistance with eating and was observed on November 13, 2012 to be fed by staff member #S107 with inappropriate feeding techniques. (124)

Resident #38 was diagnosed with a recent urinary track infection and was undergoing antibiotic therapy. The Resident was observed to eat and drink very little, only bites of food and sips of fluid taken, over the course of several meals starting November 5, 2012 and was observed to sit through most meals with minimal encouragement to eat and even less encouragement to drink. The Resident previously had a stable weight for the past year but her/his weight of November 13, 2012 indicated a significant weight loss. The Resident is assessed to be at high nutritional risk.

On November 13, 2012 at supper, Resident #38 from above was observed to be eating the second quarter of her/his sandwich. One minute later, a PSW was observed to attempt to take away the sandwich but was stopped by the Resident. Seven minutes after that, the PSW cleared the Resident's plate from the table with only one half of the sandwich eaten. The Resident was not offered dessert until LTCH Inspector intervened. (148)

Resident #32 and Resident #35, both who require assistance with eating, were not assisted with the cereal portion of their breakfast and were not provided the opportunity for a completed meal as per the home's menu. Both Residents are assessed at high nutritional risk.

2. The licensee failed to comply with O.Reg. 79/10, s. 73. (2) (a) in that no person shall simultaneously assist more than two Residents who need total assistance with eating or drinking.

It was observed during the supper meal service on November 9, 2012 that two PSWs each assisted three Residents requiring total assistance simultaneously. Of the six Residents being assisted, Resident #22 is experiencing weight loss and only consumed bites of her/his meals with no fluid taken. Resident #25 is also experiencing weight loss, minimal intake at the previous meal and snack, and did not consume all her/his supper including fluids.

WN #26: 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 subsections:

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 Resident's Council and the Family Council in developing and carrying out the survey.

The Administrator/Director of Care reported that the annual satisfaction survey was recently conducted in September 2012 and that the survey used was a corporate survey that did not have input from the home's Resident Council or the Family Council. The Program Manager who assists the Residents' Council confirmed that no survey had been taken to a Residents' Council since he was assigned to assist the council in April 2012. A review of the Residents' Council meeting minutes available from February 1, 2012 to present did not demonstrate that the Resident Council had input into the recently completed satisfaction survey nor could the Co-chair of the Residents' Council recall providing advice regarding the satisfaction survey. The President of the Family Council confirmed that the satisfaction survey was not brought to the Family Council for advice in developing or carrying out the satisfaction survey.

WN #27: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 21. Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. 2007, c. 8, s. 21.

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O., 2007, c.8, s.21, in that the home does not have written procedures for initiating complaints.

A review of policies and procedures provided to Inspector #148 by the home demonstrates that there are not written procedures for the initiating of complaints to the home or licensee.

Interview of Administrator/DOC on November 21, 2012, confirmed that the home does not have any written procedures for initiating complaints to the home or licensee.

WN #28: 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 subsections:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) an explanation of the duty under section 24 to make mandatory reports;
(e) the long-term care home's procedure for initiating complaints to the licensee;
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints;
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained;
(h) the name and telephone number of the licensee;
(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;
(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;
(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;
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge;
(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;
(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;
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package;
(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;
(q) an explanation of the protections afforded by section 26; and
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, c.78(2)(e), in that the admission package did not include the home's procedure for initiating complaints to the licensee.

A review of the admission package provided by the home demonstrates that the home does provide information related to the licensee's responsibilities under the LTCHA, however does not provide for the internal procedures for initiating complaints.

2. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.78(2)(h), in that the admission package did not include the telephone number of the licensee.

A review of the admission package provided by the home, demonstrates that the name of the licensee is provided but no phone number is provided in the admission package.

3. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.78(2)(c), in that the admission package did not include the home's policy to promote zero tolerance of abuse and neglect of Residents.

A review of the admission package, provided by the home, demonstrates that a description of the policy is included, however, the home's abuse policy is not provided in the admission package.

WN #29: 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 subsections:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.79(3)(l), in that Orders by an inspector that are in effect or that have been made in the last two years are not posted.

A tour of the home confirmed that only Orders by an inspector from October 2012 have been posted. Orders by an inspector from previous inspections are not posted. Confirmed by the home's Office Manager.

2. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.79(3)(k), in that copies of the inspection reports from the past two years are not posted.

A tour of the home confirmed that only the inspection reports from October 2012 are posted. Confirmed by the home's Office Manager.

3. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, c.79(3)(h), in that the telephone number of the licensee is not posted.

A tour of the home confirmed that only the name of the licensee was posted, the telephone number of the licensee was not posted. Confirmed by the home's Office Manager.

4. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.79(3)(p), in that an explanation of whistle-blowing protections related to retaliation was not posted.

A tour of the home confirmed that an explanation of the whistle-blowing protections related to retaliation was not posted. Confirmed by the home's Office Manager.

5. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8 s79(3)(o), in that the most recent minutes of the Family Council meeting was not posted.

A tour of the home confirmed that the most recent minutes of the Family Council meeting was not posted. Confirmed with Staff member #s103 that the home was not aware of the posting requirement and that posting of the minutes had not been discussed at a Family Council meeting as of November 7, 2012.

6. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.79(3)(j), in that an explanation of the evacuation procedures were not posted.

A tour of the home confirmed that the an explanation of the evacuation procedures were not posted.Confirmed by the home's Office Manager.

7. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.79(3)(e), in that the procedures for initiating complaints to the licensee was not posted.

A tour of the home confirmed that the procedure for initiating complaints to the licensee was not posted. Confirmed by the home's Office Manager.

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

CORRECTED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

Ontario

Ministry of Health and Long-Term Care

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

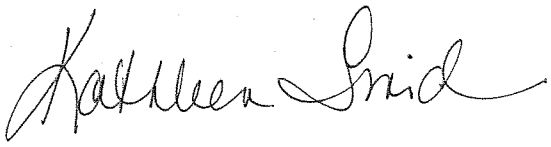
Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 r. 31.	CO #001	2012_039126_0005	124

Issued on this 10th day of December, 2012

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



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) :	KATHLEEN SMID (161), AMANDA NIXON (148), LINDA HARKINS (126), LYNDA HAMILTON (124), PAULA MACDONALD (138)
Inspection No. / No de l'inspection :	2012_199161_0003
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Date of Inspection / Date de l'inspection :	Oct 19, Nov 1, 5, 6, 7, 8, 9, 13, 14, 15, 16, 19, 20, 21, 22, 23, 27, 28, 29, Dec 4, 2012
Licensee / Titulaire de permis :	DEEM MANAGEMENT LIMITED 2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5
LTC Home / Foyer de SLD :	WELLINGTON HOUSE NURSING HOME 990 EDWARD STREET NORTH, P.O. BOX 1510, PRESCOTT, ON, K0E-1T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARYLIN BENN

To DEEM MANAGEMENT LIMITED, 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) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, 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.
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.
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.
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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that the home has in place a Skin and Wound Care program that meets the requirements under O. Reg 79/10, s.30(1).

This plan shall be submitted in writing by December 18, 2012 to Inspector: Kathleen Smid, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 347 Preston Street, 4th floor, Ottawa, Ontario. K1S 3J4 or by fax at 613.569.9670

Grounds / Motifs :

1. Resident #24 was documented as per MDS Care Plan dated 10/11/2012 to have two stage II ulcers in the coccyx area. Staff member #S108 stated that she was unsure of the current status of the Resident's stage II ulcers and referred inspector to the health record for assessments. The Resident's care provider, staff member #122, confirmed that the Resident does not currently have ulcers in the coccyx area. The Resident's health record was reviewed and the last available assessment regarding the Resident's skin ulcers in the coccyx area was dated 9/27/2012. The chart was then again reviewed with the home's RAI Coordinator and he confirmed that the last skin assessment was conducted on 9/27/2012. There were no further progress notes after the last MDS Care Plan mention above dated 10/11/2012 that indicated any further assessment regarding the Resident's identified stage II ulcers.

At the end of October 2012, Resident #42 exhibited altered skin integrity and was prescribed a topical cream. The topical cream was applied by the PSW on a daily basis. Resident #42 health care record was reviewed and no documentation was found related to the assessment or monitoring of the altered skin integrity. Registered nursing staff interviewed and they indicated that they do not always do the weekly skin assessment on Residents and they do not use a clinically appropriate assessment instrument.

A review of Resident #2's health care record and interview of registered nursing staff #S101, responsible for care demonstrates that this Resident has had a Stage 2 ulcer on left ankle since September 14, 2012 and a Stage 2 ulcer on right ankle since November 8, 2012. A review of Resident #2's health care record demonstrates that the home's registered dietitian has not completed an assessment of the Resident's current skin integrity issues. Interview with the home's Registered Dietitian on November 20, 2012, stated that she was unaware of Resident #2's Stage 2 ulcer. Minimum Data Set (MDS) Assessment dated September 14, 2012 indicates that Resident #2 had a Stage 2 ulcer on left ankle. Weekly Skin and Mouth Observation sheet completed by Health Care Aid on October 23, 2012, indicates that ankles are open. Interview of Staff member #S101 responsible for the care of Resident #2 on November 19, 2012, confirmed that the left ankle wound has been open since September 14, 2012, but was unable to confirm status of the wound prior to this date. Staff S#101 was not able to confirm when the right ankle wound opened, but suspects the wound opened November 8, 2012 based on the treatment orders. Staff #S101 stated that the skin integrity of both ankles has been an ongoing issue. Interview of Staff member #S100 on November 15, 2012, stated that weekly assessments by registered nursing staff would be expected to be completed on open wounds and that such assessments are completed in the Weekly Wound Care Report on Point Click Care. A review Resident #2's health care record and confirmation by Staff member #S100 and #S101, demonstrates that the only weekly assessment completed by a member of the registered nursing staff was on November 11, 2012.

The Administrator/Director of Care confirmed that she is responsible for leading the Skin and Wound Care Program in the home and reported that the Skin and Wound Care Program is currently not in place. She stated the home is working with a consultant to develop and implement a Skin and Wound Care Program that also includes an evaluation process of the program.

In addition, the Administrator/Director of Care confirmed that the following components of the Skin and Wound Care Program required implementation:
- the skin and wound care committee must be re-established,
- documentation of skin and wound care including updating of the care plan,
- use of assessment tools,
- scheduling of the required assessments by registered nursing staff,
- and accessing skin and wound care specialist to support the home's training needs.

Previous non-compliance was identified in September 2012 under O. Reg 79/10 s. 50 (2)iv, related to monitoring of altered skin integrity by the registered nursing staff. Action taken by the inspector included a voluntary plan of correction. (138)

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 : Jan 31, 2013

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to 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.

This plan shall be submitted in writing by December 18, 2012 to Inspector: Kathleen Smid, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 347 Preston Street, 4th floor, Ottawa, Ontario. K1S 3J4 or by fax at 613.569.9670

Grounds / Motifs :

1. The licensee has failed to comply with O.Reg. 79/10 s.49(2), in that after a fall that resulted in transfer to hospital, Resident #2 did not have a post-fall assessment conducted, using a clinically appropriate assessment instrument.

Resident #2 was found on the floor of bathroom at 2230 hours after attempting a self-transfer to wheelchair after toileting. Resident #2 complained of left shoulder pain, describing that her/his shoulder hit the wall during the fall. As documented by progress notes dated October 7 2012 at 0048, range of motion and vitals were assessed by Registered Nursing staff, pain medication was provided and the Resident was sent to hospital to assess possible fracture.

An Incident Report was completed indicating that range of motion and vitals were assessed by Registered Nursing staff, pain medication was provided, Power of Attorney was notified and the Resident was sent to hospital. Report indicates that Resident returned from hospital; shoulder and hip x-ray both negative. Report indicates the plan of action is to inform Resident #2 to call for supervision when transferring.

Review of Resident #2's health care record indicates a risk of falls. Progress notes indicate a fall on October 3 and October 18, 2012 both related to Resident self-transfers. Plan of care demonstrates a risk of falls related to medications, pain, impaired balance and coordination.

The health care record demonstrates that no clinically appropriate assessment instrument for post fall assessment was conducted related to the October 3, 6, and 18th fall. (148)
2. It is documented in the progress notes that the Resident #27 tried to get up from bed while wearing socks and slipped to the floor. Resident #27's range of motion and vital signs were assessed at the time of the fall.

The Administrator/Director of Care and staff member #S101 reported to the inspector that a Post Fall Analysis Report is to be completed after each Resident fall and is documented in Point Click Care.

There was no Post Fall Analysis Report recorded in Point Click Care for Resident #27. (124)
3. Resident #22 fell on November 6, October 6, and Sept 25, 2012 and no post fall assessment were conducted using a clinically appropriate assessment instrument that is specifically designed for falls (126)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : ~~Jan 31, 2013~~ extended to March 31, 2013
K Smid

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

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

This plan shall include:
1. Review and assessment of the process of medication administration by the multidisciplinary team.
2. To educate and re-educate all registered nursing staff related to the home's medication policies and procedures.
3. A process for ongoing monitoring of medication administration practices to ensure compliance.

This plan shall be submitted in writing by December 18, 2012 to Inspector: Kathleen Smid, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 347 Preston Street, 4th floor, Ottawa, Ontario. K1S 3J4 or by fax at 613.569.9670

Grounds / Motifs :

1. On November 14, 2012, medication Domperidone 10 mg by mouth was administered around 10:20 to Resident # 47 when the prescription indicates it is to be administered before breakfast. Staff member #S112 stated that it is difficult to pass all medications and the nurses try to priorize administration of insulin in the morning. (126)
2. (124)
3. The licensee failed to comply with O. Reg 79/10 s. 131(2) in that drugs were not administered to residents in accordance with the directions for use specified by the prescriber.

On November 14, 2012 the medication Domperidone 10mg by mouth was administered around 10:20 to Resident # 47 when the prescription indicates it is to be administered before breakfast. Staff member #S112 stated that it is difficult to pass all medications and the nurses try to priorize administration of insulin in the morning (124)

On a date in August 2012 Resident #3 was ordered a medication in patch form - two patches every morning. Resident #3's progress note nine days later in August 2012 indicates "resident telling staff members that her/his patches were put on late Friday...Patches were to go on at 06:00. staff member put them on at 10:00." November 14, 2012 discussion with staff member #S133 who wrote the progress note in August 2012 in which she indicated to the inspector that she "does not remember the incident, if I wrote it, it must be true."

On November 7, 2012 Resident #22 was ordered an antibiotic twice daily for 7 days. According to staff member # S101, the medication was delivered the evening of November 7, 2012 before 20:00 hours. At 06:30 on the morning of November 8, 2012 staff member #S101 found the unopened antibiotic bottle on the counter in the medication room. On November 13, at 14:00 discussion with Registered Pharmacy Technician at Classic Care Pharmacy who indicated to the inspector that Resident #22's antibiotics were delivered to the home on November 7, 2012 before 20:00 hours. The Medication Administration Record for resident #22 was reviewed for November 7, 2012. There is no documentation on November 7, 2012 to indicate that Resident #22 received the antibiotic which was ordered earlier in the day.

On November 13, 2012 @ 11:10 the inspector reviewed Resident #9's Medication Administration Record. There is no documentation that Resident # 9 received her/his 08:00 medications. On November 13, 2012 @ 11:20 staff member #S108 indicated to the inspector that due to competing priorities, she had not been able to administer the medications due at 08:00 this morning for Resident #9. On November 13, 2012 @ 11:11 staff member #S101 administered 08:00 medications to Resident #30.

November 15, 2012 @ 10:15: Resident # 45's Medication Administration record reviewed and the 08:00

medications for November 15, 2012 were not documented as administered. November 15, 2012 @ 10:20, discussion with Resident #45 who indicated that she/he had not received her/his 08:00 medications. November 15, 2012 @ 10:40 the inspector observed staff member #S101 administer the November 15, 2012, 08:00 medications to resident #45.

Resident #30 Medication Administration Record was reviewed. On October 12, 2012, the physician increased Resident #30's dose of a specific medication from three times per day to five times per day. The Medication Administration Record indicated that Resident #30 was to receive the five doses of this medication at 0600, 1000, 1400, 1800 and 2200 hours. On October 12, 2012, Resident #30's Medication Administration Record indicated that the resident received the specific medication at 0800, 1200, 1800, 2100 and 2200 hours. Staff member #S114 confirmed that this medication was administered at 1800, 2100 and 2200 hours on October 12, 2012. On November 1, 2012, the physician changed Resident #30's order for this specific medication to three times per day and her/his Medication Administration Record indicated that this medication was to be given at 0800, 1700 and 2100 hours. On November 4, 2012, it is documented in the progress notes that Resident #30 did not receive this medication at 1700 or 2200 hours because there was none of this medication to give. (124)

On November 14, 2012 at approximately 10:20, Resident # 47 was administered a specific medication. The Physician's Order indicates that Resident # 47 is to receive this medication before breakfast. Staff member # S112 stated that it is difficult to pass all the morning medications and the nurses try to priorize the administration of insulin to those residents requiring insulin in the morning. (126) (161)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : ~~Jan 31, 2013~~ extended to March 31, 2013 K Smid

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Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 134. 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.

Order / Ordre :

The licensee shall ensure that with any drug or combination of drugs, there is monitoring and documentation of the resident's response and of the effectiveness of the drugs appropriate to the risk level of the drugs.

Grounds / Motifs :

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

1. The licensee failed to comply with O.Reg. 79/10, s.134 s.(a) in that there was not monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.
Resident #30 had been prescribed a specific medication for pain three times per day since her/his admission in the summer of 2010.

On a date in October, 2012, Resident #30 complained of pain and received two doses of an analgesic, one of which was ineffective, as well as her/his regular doses of a specific medication. The following day (#2), Resident #30 received two doses of the analgesic for pain, again one of which was ineffective, in addition to her/his regular doses of a specific medication. On day #3 in October 2012, Resident #30's specific medication was increased from three times per day to five times per day.

There is no documented assessment of Resident #30's response to the increase in medication on day # 2 or #3 in October 2012.

Staff member #S101 reported to the inspector that after supper on a date in October 2012, Resident #30 was slow to respond and sleepy and she questioned that this may be related to the increased dose of the specific medication. Resident #30 had not had laboratory testing to determine her/his blood level of this medication since admission. On a date in October 2012, Resident #30 was sent to hospital and was diagnosed with a toxicity to the specific medication.

On a date in October 2012 Resident #30 was prescribed an analgesic every four hours as needed, to maximum of 4 grams/day. Between a latter date in October 2012 and fourteen days later, Resident #30 received nineteen doses of the analgesic and eight doses had no effectiveness documented.

On a date in November 2012, it is documented that Resident #30 is experiencing excruciating facial pain on the left side of her/his face. (124)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : ~~Jan 31, 2013~~ extended to March 31, 2013 KSmd

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA 2007, S.O. 2007, c.8, s. 6(4) to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

The plan shall include:
1. Clarification of the process by which the Registered Dietitian and Food Service Supervisor are to be notified by nursing staff of changes to resident's health status.
2. Clarification of the process by which the nursing staff (PSW, RPN, RN) communicate amongst themselves any changes or concerns related to residents' nutritional condition/status.

This plan shall is to be submitted in writing by December 18, 2012 to Inspector: Kathleen Smid, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 347 Preston Street, 4th floor, Ottawa, Ontario. K1S 3J4 or by fax at 613.569.9670

Grounds / Motifs :

1. Resident #38 was observed during the first dining observation of the inspection on November 5, 2012 not eating or drinking. RPN #S101 stated that the Resident had a recent urinary tract infection with antibiotic therapy and that she/he had not been eating or drinking well since the previous Friday (November 2, 2012). Resident #38 was observed again on November 8, 2012 at breakfast and ate little and had less than one half of her/his mug of coffee. On November 9, 2012 Resident #38 was observed at lunch again to not eat and only consumed sips of her/his coffee. It was also noted that the Resident consumed very little food and fluids at snack time as well. Discussion was held with the home's Registered Dietitian the evening of November 9, 2012 and she confirmed that she had not been communicated to regarding changes in Resident #38's health condition and therefore had not assessed the Resident. The Resident's weight was measured the following week on November 13, 2012 and it was noted that she/he experienced significant weight loss.

Resident #30 is experiencing facial pain and decreased food intake at meals times as observed on November 8 and 9, 2012. This Resident is at high nutritional risk and is exhibiting an undesirable pattern of weight loss. The home's Registered Dietitian confirmed that she was not made aware of issues with Resident #30's health condition and further reported that she is often not made aware of concerns with Residents until the Resident has exhibited weight loss which gets identified by her through the monthly weights.

Resident #25 was observed at lunch on November 9, 2012 to eat very little and only take sips of thickened water. The Resident was observed again at supper that same day and evening staff assisting the Resident reported that she was unaware that the Resident had poor food and fluid intake at lunch. This Resident has exhibited a gradual, undesirable history of weight loss and is assessed to be high nutritional risk.

Discussion was held with the RPN #S111 regarding the communication of Resident nutritional concerns among nursing staff. RPN #S111 stated that the 24 hour report binder is used to communicate information from shift to shift but that the contents of the 24 hour report are dependent on communication from the PSW to the registered staff and she further stated that often times information is missed. The 24 report binder was reviewed for the period of November 5 – 9, 2012 and no Resident nutritional concerns were documented. (138)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : ~~Jan 31, 2013~~ extended to March 31, 2013 KSmid

Order # /
Ordre no : 006

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

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that there is a written plan of care for Resident #51 and #22 that sets out clear directions to staff and others related to the residents responsive behaviours.

This plan shall is to be submitted in writing by December 18, 2012 to Inspector: Kathleen Smid, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 347 Preston Street, 4th floor, Ottawa, Ontario. K1S 3J4 or by fax at 613.569.9670

Grounds / Motifs :

1. The licensee failed to comply with LTCHA 2007, S.O., 2007, c.8, s. 6.(1)(c), in that the Resident's plan of care did not set out clear directions to staff and other/hiss who provide direct care to the Resident.

For meals, Resident #51 is seated in a wheelchair and restrained by a lap belt.

Resident #51's plan of care stated that a feeding restraint is used and well tolerated to allow Resident to stay seated and finish her/his meal.

During the supper meal on November 9, 2012, inspector #138 observed Resident #51 becoming agitated and pushing against the wheelchair. A Personal Support Worker intervened and staff later provided assistance with herhis meal.

During the supper meal on November 14, 2012, inspector #124 observed Resident #51 rocking against the restraint such that she/he moved the wheelchair which had brakes applied approximately four feet, on more than one occasion. Staff member #S139 returned the Resident to her/his table each time and was heard telling another PSW that she didn't know what to do. Staff member #S139 stated that if there was a staff member who could assist Resident #55 with her/his meal that her/his agitation would decrease. S#139 stated that she thought Resident #51 was hungry.

Resident #51's plan of care does not identify the Resident's agitation at meals and does not set out clear directions to staff in how to deal with this agitation.

Resident #22 has been exhibiting agitated behaviors mostly in the evening around supper time for the past several months. On November 14, 2012, Inspector #124 observed Resident #22 becoming increasingly agitated after supper, wanting to go to the bathroom. After an attempt by 3 staff members to bring Resident #22 to the bathroom, she/he was left in the hallway. Resident #22 continuing to be agitated, kicking the charts racks and the gate at the nursing station. The Regional Director requested that staff make another attempt to bring the resident to the bathroom. Resident #22 was brought to the bathroom and then was put to bed. No further behavior observed. The care plan did not reflect the resident's responsive behaviors. (124)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 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

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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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.

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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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 4th day of December, 2012

Signature of Inspector / Signature de l'inspecteur : Kathleen Smid Feb 1, 2013

Name of Inspector / Nom de l'inspecteur : KATHLEEN SMID

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