Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 22, 2015	2014_275536_0031	T-000113-14	Resident Quality Inspection

Licensee/Titulaire de permis

REGENCY LTC OPERATING LP ON BEHALF OF REGENCY
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

THE WESTBURY
495 The West Mall ETOBICOKE ON M9C 5S3

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

CATHIE ROBITAILLE (536), KELLY HAYES (583), THERESA MCMILLAN (526)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 2, 3, 4, 5, 8, 9, 10 and 11, 2014

The following inspections were conducted concurrently during this RQI. Log #T-000152-14, T-000353-14, T-000361-14, T-001012-14, T-001032-14, T-001086-14, T-001112-14 and T-001278-14

During the course of the inspection, the inspector(s) spoke with residents, families, regulated and unregulated workers, Environmental Services Manager,Registered Staff,Minimum Data Set(MDS)Co-ordinator, Behavioural Support Ontario (BSO), Education Co-ordinator, Dietary Services Supervisor (DSS), Director's of Care (DOC) and the Administrator

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A) Resident #042's clinical record indicated that the resident was a high risk for falls and had sustained several falls in 2013 and three falls during identified months in 2014. The progress notes indicated the following: the resident sustained a fracture of the arm after falling in their room on an identified date in 2013; the resident fell on two identified dates in 2014 with no injury; and the resident was found in the lying position on their side on the floor beside their bed on an identified date and time in 2014. The resident was assessed at that time and was found to have no apparent injury as a result of the fall. However, on an identified date in 2014 the resident was sent to hospital, was diagnosed with a fracture of the hip that was surgically repaired, and then returned to the home on

an identified date in 2014.

i) Resident #042’s RAI MDS assessment completed on an identified date in 2014 indicated that the resident used a cane, walker, or crutch and that the resident used a wheelchair as their primary mode of locomotion. The document the home referred to as the "care plan" completed on an identified date in 2014 indicated that the resident was using a wheelchair and did not indicate the use of a cane, walker or crutch. A Personal Care Provider (PCP) who provided direct care of the resident stated to the Inspector that the resident used a wheelchair. The home’s two DOC’s indicated that the resident did not prefer to use the wheelchair but rather used a walker to ambulate.

ii) Resident #042’s RAI MDS assessment completed on an identified date in 2014 indicated that the resident was not able to balance while standing without physical help and that a wheelchair was the resident’s primary mode of locomotion. The document the home referred to as the "care plan" for resident #042 on an identified date in 2014 did not indicate the resident’s plan of care regarding the resident’s mobility.

iii) During interview with the LTC Inspector, a PCP who had cared for resident #042 stated that the resident used a wheelchair and would try to get up from the wheelchair and that staff applied a chair alarm. The documents the home referred to as the “care plans” for resident #042 completed on identified dates in 2014, indicated that the resident was a high risk for falls and that staff were to ensure appropriate safety device was in use (ie. Hi/lo bed); apply crash mattress at night, bed alarm and hip protector. The care plans did not include the use of a chair alarm or that the resident had been attempting to get up from their chair.

The home’s two DOC’s confirmed that there were unclear directions for staff regarding falls prevention for resident #042.

B) Review of clinical records indicate that resident #043 was admitted to the home on an identified date and was a high risk for falls. The resident’s RAI MDS assessment completed on an identified date in 2013 indicated that the resident used a cane, walker, or crutch; wheeled self; was wheeled by other person; and the wheelchair was their primary mode of locomotion. Interview with registered staff indicated that the resident was admitted with a wheelchair and would rarely use a walker.

The document the home referred to as resident #043's "care plan" dated an identified date in 2014, that was used to guide the resident's care did not include information about

the resident's modes of locomotion or mobility. According to progress notes, the resident sustained a fall on an identified date in 2014, was diagnosed with a fracture which was surgically repaired. The DOC confirmed that the resident's plan of care was unclear as the care plan did not indicate the resident's mode locomotion or mobility. [s. 6. (1) (c)]

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

The bath schedules for all eight floors were reviewed. Seven out of eight bath schedules did not identify whether residents had a bath or a shower.

The staff interviewed all stated they knew what resident's preferences were in their care plans. The bath schedule for the identified floor stated in brackets beside three resident's names, that they were to have a shower. Inspector asked staff on that floor if that meant that the remainder of the residents had baths. The staff advised the inspector that all residents but resident #050 received showers. On the bath schedule resident #050 had "shower" written beside their name twice. The bath schedules on all eight floors, did not provide clear direction to staff who provided direct care to the residents. [s. 6. (1) (c)]

3. The licensee has failed to ensure that resident #048 and their substitute decision maker were given the opportunity to participate fully in the development and implementation of the resident's plan of care.

On an identified date, resident #048 was admitted to the home. Review of the bath schedule on an identified date in 2014, had resident #048 listed as having two showers a week. Review of resident #048's plan of care which the home refers to as the "care plan" identified that the resident was to have two showers per week. The inspector spoke with the Power of Attorney (POA) for resident #048 who stated, the resident's preference was a bath. The POA confirmed that they were not asked any particulars about the resident's preferences in regards to bathing, when they were doing the admission paperwork, or in the days following the admission.

The Director of Care (DOC) was advised by the Inspector of resident #048's preference, and was asked to speak with the POA. The home failed to ensure that resident #048 and their POA were given the opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

4. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) Resident #049's Resident Assessment Inventory Minimum Data Set (RAI MDS) completed on an identified date in 2014, indicated that the resident required extensive assistance from two or more persons to maintain personal hygiene including oral care. The resident's family stated that they were concerned that the resident's teeth were not being cleaned as well or as frequently as necessary. The document the home referred to as the "care plan" completed on an identified date in 2014 and the associated Kardex indicated that the resident had upper and lower natural teeth and directed staff to help/brush the resident's teeth after each meal.

On an identified date in 2014, after breakfast and lunch, the resident was observed to have unclean teeth. During interview with the inspector, a Personal Care Provider (PCP) stated that they brushed the resident's teeth while the resident was in bed prior to breakfast, and did not brush teeth after breakfast. The PCP confirmed that the plan of care directed staff to brush the resident's teeth after each meal and that the plan of care had not been followed. [s. 6. (7)]

5. The licensee has failed to ensure that different approaches were considered in the revision of the plan of care when a resident was reassessed and the plan of care reviewed and revised because the plan of care was not effective.

A)Resident #041 fell on an identified date in 2013, and sustained a fracture. Resident #041’s clinical record indicated that the resident was a high risk for falls. The resident sustained six falls between identified dates in 2013. The document the home referred to as the "care plan" for resident #041 completed on an identified date in 2013, indicated that the resident used a walker; that staff were to monitor the resident every 30 minutes; and to remind resident to call for assistance when ambulating. Resident #041 sustained a fracture after falling on an identified date in 2013. After the residents fracture, the care plan was reviewed on an identified date in 2013, directed staff to continue with the current interventions. The resident subsequently fell and sustained a fracture on an identified date in 2013 at which time the resident required surgery.

B) Resident #044 fell on an identified date in 2014, and sustained a fracture. Resident #044 was assessed as a high risk for falls using the Morse Fall Risk Assessment on an identified dates in 2014. Progress notes indicated that the resident fell on identified dates

in 2014. On an identified date in 2014, the resident fell while in the washroom, was sent to hospital and was diagnosed with a fracture.

The documents the home referred to as the "care plan" completed on identified dates in 2014, for resident #044 indicated that the resident was a high risk for falls and directed staff that resident required assistive aids for walking-walker; to provide supervision and cuing with difficult maneuvers of turning; to monitor resident every hour; to remind resident of correct use of walker; to place all necessary items within reach; and to apply crash mattress to floor.

Review of resident #044's plan of care indicated that the plan of care was not revised when the care set out in the plan had not been effective after resident falls on two identified dates in 2014.

The DOC confirmed that the resident's plan of care were not revised to include different approaches to falls and injury prevention for resident #044. [s. 6. (11) (b)] (526) [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the plan of care sets out clear direction to staff and others who provide care; the resident and substitute decision maker are involved in the implementation and development of the plan of care and that different approaches are considered when the plan of care is no longer effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) Resident #041 fell on an identified date in 2013 and sustained a fracture. Resident #041 was a high risk for falls. The resident's clinical record indicated that the resident sustained five falls between identified dates in 2013. As a result of a fall in 2013, the resident sustained a fracture for which the resident was assessed and returned to the home. On an identified date in 2013 the resident's fall resulted in a fracture leading to hospitalization, treatment and return to the home on an identified date in 2014.

The document the home referred to as the "care plan" for resident #041 completed on an identified date in 2013, directed staff to monitor the resident every 30 minutes. Interview with Personal Care Provider (PCP)staff indicated that they monitored the resident according to the plan of care. Review of the resident's health record indicated that the staff had not documented that the resident was monitored every 30 minutes as stated by the PCP, and directed in the resident's plan of care. The DOC's confirmed that the staff in the home did not document monitoring resident #041 every 30 minutes between a fifteen day time frame in 2013, according to the plan of care.

B) An inspection was completed for a Critical Incident involving resident #042 who fell on an identified date in 2014 and sustained a fracture. Resident #042 was a high risk for falls. The resident's progress notes indicated that the resident sustained a fall on an identified date in 2014, was sent to hospital, diagnosed with a fracture, and was treated and returned to the home on an identified date in 2014. The document the home referred to as the "care plan" for resident #042 completed on an identified date in 2014, directed staff to monitor the resident hourly. Interview with Personal Care Provider staff indicated that they monitored the resident hourly. Review of the resident's health record indicated that the staff had not documented that they had monitored the resident hourly. The two

DOC's confirmed that the staff in the home did not document that the resident was monitored hourly.

C) Resident #043 fell on an identified date in 2014 and sustained a fracture. A review of the resident #043's clinical health records, they were a high risk for falls. A review of the resident's progress notes stated that the resident fell on an identified date in 2014. The resident was diagnosed with a fracture that required surgery. The document the home referred to as the "care plan" for resident #043 completed on an identified date in 2014, directed staff to monitor the resident every 30 minutes. Interview with a Personal Care Provider (PCP) indicated that staff would monitor the resident frequently, and that they would document resident monitoring on the behaviour monitoring sheet. Review of the resident's health record indicated that the staff had not documented that they had monitored the resident every 30 minutes between two identified dates in 2014.

The DOC's were unable to confirm that staff had documented that staff had monitored resident #043 every 30 minutes immediately prior to and at the time of the resident's fall.

D) Resident #044 fell on an identified date in 2014 and sustained a fracture. A review of resident #044's clinical health records verified, they were a high risk for falls. According to progress notes, the resident fell on three identified dates in 2014. After one of the falls in 2014, the resident was sent to hospital, and was diagnosed with fracture. The document the home referred to as the "care plan" for resident #044 completed on identified dates in 2014, directed staff to monitor the resident hourly. Interview with registered staff indicated that staff would monitor the resident frequently. The staff could not confirm that the resident was monitored, when the resident left the care area.

Review of the resident's health record resulted in no evidence that resident had been monitored hourly as per the plan of care between an identified date in 2014 and the date of the resident's fall 2014. The DOC was unable to confirm that staff had documented that staff had monitored resident #044 hourly according to the resident's plan of care. [s. 30. (2)] (526) [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that actions are taken with respect to a resident including assessments, reassessments, interventions and the resident's responses to the interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed by the method of his or her choice.

During Stage One of the Resident Quality Inspection (RQI), resident #002 and resident #029 identified that a shower was not their choice, that they preferred a bath. Both residents stated that having a bath was not an option.

Review of the bath schedule for all eight floors identified that only two residents out of 187 residents had a tub bath. Personal Care Providers (PCP) who spoke with inspector identified that residents had to be cognitively aware to use the Aquamax tubs on each floor, stating residents had to be able to either step into tub through the access door, or be able to follow direction and hold onto the rails of the tub, so they did not slide down in the tub.

On seven out of eight floors the staff spoken to, confirmed that the tub was not used to bath residents. On an identified date in 2014, resident #048 was admitted to the home. Review of the bath schedule on an identified date in 2014, identified that resident #048 was to have two showers a week. The inspector spoke with the Power of Attorney (POA) for resident #048 who stated, the resident's preference was a bath. The POA also confirmed that they were not asked about their preference. The management of the home stated that they were unaware that residents were not being provided with a choice, in regards to having a bath or a shower. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that each resident of the home is bathed by the method of his or her choice, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A review of the plan of care indicated resident #022 sustained a skin tear on an identified date in 2014 during a transfer and toileting procedure. A review of the plan of care which the home refers to as the "care plan", identified that resident #022 required: extensive assistance with two staff members using the sit/stand mechanical lift for transfers on and off the toilet; 2 staff members during toileting and one person to provide care and the other staff member to provide support.

The Director of Care completed an investigation on an identified date in 2014 when resident #022 sustained a skin tear the resident was transferred and toileted by one staff member and the sit/stand mechanical lift was not used. In a document written by the Personal Care Provider (PCP) who provided the care for resident #022 it was confirmed that on an identified date in 2014 resident #022 was not transferred with the sit/stand lift, and that the transfer and toileting care was provided with one staff member.

In an interview with the Administrator it was confirmed that staff did not use safe transferring devices and techniques, or safe positioning techniques when transferring and toileting resident #022. [s. 36.]

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 and ensuring that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #044 was identified as a high risk for falls using the Morse Fall Risk Assessment on an identified date in 2014. The resident's health record indicated that the resident sustained a fall on an identified date in 2014, which was nine months since their previous fall. Review of the resident's clinical record indicated that the resident had not been assessed after the fall that occurred on an identified date in 2014, using a clinically appropriate assessment instrument that was specifically designed for falls. This was confirmed by the DOC. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that when the resident has fallen, the resident is assessed and a post-fall assessment is conducted by using a clinically appropriate assessment instrument, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful altercations between and amongst residents.

On an identified date in 2014, an altercation occurred between resident #046 and resident #051. Resident #046 was observed walking with resident #051 when an argument ensued and resident #046 was observed slapping resident #051. The camera footage reviewed by the home the following day, identified that resident #051 had hit resident #046 with a face towel and then resident #046 hit resident #051 on their arm. The two residents were separated without further incidence.

The plan of care for resident #046 completed on an identified date in 2014, which the home refers to as the care plan; when reviewed, did not have any identifying factors based on an interdisciplinary assessment that could potentially trigger such altercations. The care plan did identify that resident #046 could be verbally aggressive.

On an identified date in 2014, resident #046, was witnessed hitting roommate resident #047 repeatedly causing bruising and injury. Following that altercation, interventions were put into place. Following the incident that occurred on an identified date in 2014, the home failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful altercations between and amongst residents. Review of progress notes for an eight months period in 2014 indicated that on an identified date in 2014 resident #046 had threatened to harm staff. Again on an identified date in 2014, resident #046 scratched and pinched staff. The plan of care for resident #046 was not updated to reflect the physical aggression that was being exhibited. [s. 54. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that steps are taken to minimize the risk of altercations and potentially harmful altercations between and amongst residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home's policy [Resident Safety and Risk Management for Resident Falls #LTC-CA-WQ-200-07-08 reviewed in November 2014] indicated that if a resident who was at high risk for falls had sustained a fall for the first time in a quarter, staff were directed to completed the following: "Morse Fall Risk Assessment; Risk Management - PCC; Progress Notes using the 'Occurrence Note' type; and Post Fall Analysis in Point Click Care".

Resident #044 was assessed as a high risk for falls on an identified date in 2014 using the Morse Falls Risk assessment. The resident's health record indicated that the resident sustained a fall on an identified date in 2014 which was nine months since their previous fall. Review of the resident's clinical record indicated that the resident had not been assessed after this fall according to the home's policy. This was confirmed by the DOC. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee did not ensure that the homes policy on Medication Incidents was complied with:

On an identified date and an identified time, resident # 045 was given the wrong medication. The homes policy [Medication Incidents #LTC-CA-WQ-200-06-11-revision date: November 2014] stated to "assess the resident every 30 minutes for the next four hours to confirm no adverse effects on the resident". Review of the clinical record for resident #045 identified that this did not occur. This was confirmed by the Director of Care. [s. 8. (1) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The Licensee has failed to ensure that all doors leading to the outside of the home other than doors leading to secure areas that preclude exit by a resident were kept closed and locked.

On an identified date in 2014 at 1542 hours(hrs) the Inspector heard an alarm sounding on the main floor, and felt cold air blowing down the hallway. Upon inspection, the Inspector noted the door to the shipping area unlocked and the door leading to the outside from the shipping area unlocked and wide open. The door leading to the dumpster located outside of the home could be seen while the Inspector was standing in the hallway within the home. This opened door was located just outside of a resident lounge area where two residents were observed self ambulating while in their wheelchairs in the hallway, just outside of the door leading from the shipping area into the hallway. The alarm for the door to the outside continued to sound.

Between 1542 and 1555 hrs, three staff persons were observed to walk through the main lobby area where the alarm could be heard. They did not inspect as to where the alarm was coming from. The receptionist asked a maintenance working to disengage the alarm; however, the doors remained unlocked and opened to the outside. At approximately 1600 hrs, the Social Services Manager entered the hallway and advised the Inspector that the door should be locked at all times, and proceeded to close and lock the door leading to the outside, and the door leading from the shipping area to the resident area hallway. [s. 9. (1) 1. i.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a response was made in writing within 10 days after receiving advice from the Family Council related to concerns or recommendations made to the licensee.

Review of 14 Family Council meeting minutes held between January 6, 2013 and November 13, 2014, indicated that the home had not responded in writing within 10 days to concerns or recommendations raised during Family Council meetings. Interview with a Family Council representative and the Administrator confirmed this. [s. 60. (2)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Family Council was consulted regularly or at least every three months.

Review of 14 Family Council meeting minutes held between January 6, 2013 and November 13, 2014, indicated that the home had not consulted with Family Council at least every three months. Interview with a Family Council representative and the Administrator confirmed this. [s. 67.]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

Review of the home's Residents' Council meeting minutes for 14 Council meetings held between August 28, 2013 and October 29, 2014, indicated that the home had not sought the advice from the council in development of the Satisfaction Survey or in acting on it's results. Interview with the Residents' Council representative indicated that the home's representative had told the Council that the Survey was meant to stay uniform so that the licensee could compare the results between homes using the same survey. The Council had been asking for input into the development of the Survey over the past four years and submitted a letter of complaint to the licensee on August 19, 2014. The Administrator confirmed that prior to distributing the 2014 Satisfaction Survey to family and residents, the home had not sought the advice of the Council on the creation of the Satisfaction Survey. [s. 85. (3)]

2. The licensee has failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey and in acting on its results.

Review of 14 Family Council meeting minutes held between January 6, 2013 and November 13, 2014, indicated that the home did not seek the advice of the Council in developing and carrying out the satisfaction survey or in acting on its results. Interview with a Family Council representative and the Administrator confirmed this. [s. 85. (3)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents were communicated to the Family Council.

Review of 14 Family Council meeting minutes held between January 6, 2013 and November 13, 2014, indicated that the home had not communicated improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents. Interview with a Family Council representative and the Administrator confirmed this. [s. 228. 3.]

Issued on this 28th day of January, 2015

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

Original report signed by the inspector.