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
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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 18, 19, 20, 21, 22, 25, 26, 27, 28, 29, Jul 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, 23, 24, 25, 26, 27, 2012	2012_103164_0017	Resident Quality Inspection

Licensee/Titulaire de permis

SPENCER HOUSE INC.
835 West Ridge Blvd, ORILLIA, ON, L3V-8B3

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

SPENCER HOUSE INC.
835 West Ridge Blvd., ORILLIA, ON, L3V-8B3

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

GLORIA STILL (164), DIANE BROWN (110), LYNN PARSONS (153)

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, Doctor, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Staff, Personal Support Workers (PSW), Registered Dietitian, Occupational Therapist, Physiotherapist, Environmental Service Manager (ESM), Housekeeping Supervisor, Program Manager, Housekeeping staff, Resident Relations Co-ordinator, Infection Control Practitioner, Food Service Supervisor, Food Service Workers, Residents, Family members

During the course of the inspection, the inspector(s) reviewed: policies and procedures, health care records, in-service education records, personnel records, volunteer records. Observed: staff and resident interactions, provision of care. Conducted environmental scan of the home.

The following log numbers were inspected during this inspection and findings included: T-2786-11; T-2705-11; T -002700-11
The following Critical Incidents were inspected during this inspection and findings included: Critial Incident #2971-000018-12; #2971-000019-12; #2971-000020-12

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

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every alleged or suspected incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated.
The licensee failed to investigate an incident of alleged sexual abuse involving an identified resident and an agency registered nurse. The resident reported to the registered practical nurse on May 3, 2012 that on the night shift of May 2, 2012 an agency registered nurse inappropriately touched the resident during an assessment and introduced himself as a physician. The registered practical nurse reported the incident of alleged sexual abuse to the registered nurse on May 3, 2012. The registered nurse notified the licensee and agency electronically of these allegations on May 4, 2012. No further investigation was completed or additional follow-up action was taken by the licensee until it was brought to their attention by the inspector on July 10, 2012.

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. 229. Infection prevention and control program

Specifically failed to comply with the following subsections:

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 ensure residents admitted to the home are 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.
Twelve identified residents admitted during the period January 3, 2012- June 11, 2012 and residing in all areas of the home were not screened for tuberculosis within 14 days of admission. This information was confirmed through interview with the Infection Control Co-ordinator and registered nurse. As of July 16, 2012 the twelve identified residents had still not been screened for tuberculosis.

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 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 :

1. The licensee did not ensure that every resident has the right to be properly care for in a manner consistent with his/her needs.
A registered nurse initiated an Occupational Therapist "Rehabilitation Services Referral" on December 6th, 2011 for an identified resident. The purpose of the referral was to request an assessment of resident's "increased contracture". An interview with the Occupational Therapist (OT) and a review of documentation revealed that the OT's assessment of resident's "increased contracture" was completed April 30th, 2012. The OT reported that it was an unusually long time before assessing this resident. [s. 3. (1) 4]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that Residents' Rights are fully respected and promoted including:
- the right to be properly cared for in a manner consistent with his/her needs, to be implemented voluntarily.

WN #4: 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).

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

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the plan of care is provided to the resident as specified in the plan. The written plan of care for an identified resident at risk for swallowing problems directed staff to attempt to position the resident in an upright position and encourage him to lift his/her chin when eating and drinking.
On June 26, 2012 it was observed that registered staff administered the resident's prescribed 12:00 p.m. medications while the resident was lying supine in bed. The registered staff did not place the resident in an upright position as per the resident's plan of care to safely administer medications and fluids. [s. 6. (7)]
2. The licensee did not ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and when the resident's care needs change.
An identified resident at high risk for falls, fell May 26th, 2011. The identified resident was not reassessed and the plan of care revised following said fall. Registered staff confirmed that no changes to interventions were made following the fall. The identified resident fell June 27th, 2011 resulting in injury. [s. 6. (10) (b)]
3. The licensee did not 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.
An identified resident at high risk for falls, fell May 26th, 2011. The identified resident was not assessed by physiotherapy following the fall. An interview with the home's physiotherapist confirmed that an assessment should have been completed for identified resident following the fall. The home's Acting Director of Care confirmed that a physiotherapy referral should have been initiated by nursing after the resident's May 26th, 2011 fall. s. 6. (4) (a)]
4. The licensee did not ensure there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.
An identified resident at high nutritional risk related to low BMI has a written plan of care directing staff to "provide milk or yogurt daily". Documentation in the same plan of care states resident dislikes yogurt. Resident interview confirmed the resident dislikes yogurt and that the resident has a preference for milk. Dietary staff were interviewed to clarify their understanding of directions to "provide milk or yogurt daily". Staff reported they were not clear on when and what to offer. [s. 6. (1) (c)]
5. The written plan of care does not set out clear directions to staff and others who provide direct care to the resident.
The written plan of care for identified resident indicates the resident's skin is intact and does not include skin care interventions. On July 9, 2012 registered staff reported the resident had multiple skin issues including: dry skin, reddened areas, a dressing on the left arm, a stage 2 ulcer, bruising and scabs on upper extremities. [s. 6. (1) (c)]
6. The written plan of care for an identified resident does not set out clear directions for the staff and others who provide direct care to the resident related to number of servings required to meet the fluid requirements of 1500 mls per day.
The written (pink paper) Nutritional Plan of Care - printed June 27, 2012 - reassessed April 13, 2012 revealed the following conflicting information related to number of daily fluid servings to be offered to the resident. Expected Outcome section: Resident will consume a maximum of 1500 mls. (15 servings) daily.
Interventions: Nursing to monitor oral fluid intake and document, remind resident that their fluid intake should not exceed 1500 mls/day (12 servings).
The registered staff and registered dietitian confirmed a discrepancy on the written nutritional plan of care relating to the number of fluid servings to meet the resident's fluid goal. [s. 6. (1) (c)]
7. An identified resident's written plan of care failed to provide clear directions to staff related to oral status and cleaning of teeth. The identified resident's written plan of care indicates the resident "only wears lower dentures-does not wear upper denture". The written plan of care also includes "daily cleaning of teeth or dentures, or daily mouth care by client or staff".
When interviewed the resident confirmed he/she has upper dentures and some lower teeth which was also observed by the inspector. Staff when interviewed reported the resident has upper and lower dentures and staff were not aware the resident had any natural teeth. [s. 6. (1) (c)]
8. The written plan of care does not set out clear directions to staff and others who provide direct care to the resident.
The written plan of care for an identified resident does not identify that the resident has a chronic skin condition and interventions to manage this condition when exacerbated were not indicated. During this inspection the resident was observed to be experiencing an exacerbation of this chronic condition. [s. 6. (1) (c)]
9. The written plan of care does not provide set out clear directions to staff and others who provide direct care to the resident. The written plan of care for an identified resident indicates the resident has a trunk restraint. The resident was observed without a restraint and staff reported the resident is not restrained. Staff reported the resident used a lap belt approximately 6 months ago and was able to undo it therefore, it was not a restraint. [s. 6. (1) (c)]
10. The written plan of care does not provide clear directions to staff and others who provide direct care to the resident.

The written plan of care for an identified resident does not identify the need or application of a positioning device for the right hand contracture. Identified resident requires a right hand positioning aide to be in place at all times for a contracture according to an interview with and documentation by the Occupational Therapist. [s. 6. (1) (c)]
11. The written plan of care does not provide clear directions to staff and others who provide care to the resident.
The written plan of care for an identified resident does not include nail care.
An identified resident was observed to have dirty fingernails during the course of the inspection. On July 10, 2012, PSW staff confirmed the resident's fingernails required cleaning. [s. 6. (1) (c)]
12. The written plan of care does not set out clear directions to staff and other who provide direct care to the resident.
The written plan of care for an identified resident indicates the resident is usually continent of bladder function. PSW staff reported the resident is incontinent of bladder requiring incontinence interventions. [s. 6. (1) (c)]
13. The plan of care does not set out clear directions to staff and others who provide direct care to the resident.
The written plan of care for an identified resident indicates the resident has dentures and/or removable bridge; daily cleaning of teeth or dentures, or daily mouth care by client or staff. The identified resident will place dentures in mouth. PSW staff provided conflicting information that was not consistent with the plan of care. A PSW staff member reported the resident has no teeth, staff clean the resident's dentures and cue the resident to rinse his/her mouth and brush around the gums; another PSW staff member reported the resident has a partial plate and some natural teeth which staff brush. [s. 6. (1) (c)]
14. The written plan of care does not set out clear directions to staff & others who provide direct care to the resident.
The plan of care for an identified resident indicates that the resident requires set up assistance to maintain oral hygiene daily. PSW staff reported the resident requires total assistance for oral hygiene and in the past month the resident's status has deteriorated and the resident now clenches his/her lips and refuses to rinse his/her mouth. [s. 6. (1) (c)]
15. The written plan of care does not set out clear directions to staff & others who provide direct care to the resident.
The written plan of care for an identified resident includes: daily cleaning of teeth or dentures; indicates the resident has dentures and/or removable bridge; does not indicate oral care to be provided in a.m. The PSW staff member on day shift reported staff brush the resident's teeth in the morning; the evening PSW staff member reported staff clean the resident's upper & lower dentures in the evening and that the resident has no teeth of her own. [s. 6. (1) (c)]
16. The licensee did not ensure the resident was reassessed and the plan of care was revised when the resident's care needs changed.
The plan of care for an identified resident was not reassessed and revised related to transfer status, changes to activities of daily living and pain management following a fall which required surgical intervention and readmission from hospital. The failure to revise the plan of care was confirmed during interview with the DOC. [s. 6. (10) (b)]
17. The written plan of care does not set out clear directions to staff and other who provide care to identified resident.
The written plan of care for identified resident indicates the resident wanders but does not include interventions to address wandering. The resident is wheelchair dependent and observed not to be able to self propel.
PSW staff reported they take the resident to the TV lounge or to the resident's room to watch TV when the resident is asking repetitive questions. This intervention was not included in the written plan of care. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure:
- the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident
- that staff and others involved in the different aspects of care with 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 resident is reassessed and the plan of care reviewed and revised when the resident's care needs change
- the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #5: 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. (1) Every licensee of a long-term care home shall ensure that,
(a) there is an organized program of housekeeping for the home;
(b) there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents; and
(c) there is an organized program of maintenance services for the home. 2007, c. 8, s. 15 (1).

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 did not ensure that the home, furnishings and equipment are kept clean and sanitary.
Tour completed on June 18, 2012 identified numerous areas of the home that require cleaning, examples include: walls, floors and baseboards throughout resident home areas; chairs in lounges were observed to be stained, soiled and worn; the table legs on 8 out of 9 tables were soiled in an identified resident dining room.
Observations completed on June 26, 2012 at 12:05 p.m. on identified resident home areas regarding previously observed housekeeping issues revealed the following information:
- observed soiled, black caulking around base of toilet in identified residents' washroom
Interview with ESM confirmed collection of dirt at baseboards; floor machine is causing indents in baseboard where dust and dirt collects. He also confirmed stains on chairs in lounge.
The Housekeeping Supervisor confirmed the caulking at the base of the toilet in identified residents' room required cleaning.
Review of deep cleaning records indicates an identified residents' room was not cleaned between January 31, 2012 and May 30, 2012. The Housekeeping Supervisor confirmed resident rooms are scheduled to be deep cleaned every 6 weeks and was unable to explain why the residents' room was not included in the audits completed for March 2012. [s. 15. (2) (a)]
2. The licensee has not ensured that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. It was observed that walls in hallways are not in a good state of repair as wall paper is loose and ripped; hallway walls and walls in identified resident rooms require patching and repainting; outside an identified residents' room a picture on the wall has wood exposed with an approximate 2" area with small splinters; the paint is chipped on the entrance doors to a resdient lounge; the arms of the chairs in two identified nursing stations are in disrepair and are held together with tape and/or kling; the tub transfer chair in a tub room was observed to be scratched and gouged thereby causing an issue for cleaning and infection control; on June 19, 2012, a ceiling tile was missing in a shower room; on June 21, 2012, the toilet paper dispenser was broken in a shower room; on June 21, 2012 the toilet paper holder tube in identified resident room was missing.
On July 11, 2012 during a tour with the ESM it was observed that the ceiling tile in the aforesaid shower room was replaced; the broken toilet paper dispenser roll in the aforesaid tub room was replaced; the missing toilet paper holder tube in the identified resident room was replaced. [s. 15. (2) (c)]
3. The licensee did not ensure there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents. Interviews with nursing staff, laundry staff and the ESM identified current practice is not consistent with the home's "Lost/Missing Clothing" (V8-300) policy related to completion of "lost/missing item form, process to be followed when item(s) not located in laundry and follow-up when item(s) remain lost. Two residents identified during this inspection reported missing clothing items have not been found. [s. 15. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance shall ensure:
- the home, furnishings and equipment are kept clean and sanitary
- the furnishings and equipment are maintained in a safe condition and in a good state of repair
- there is an organized program of laundry services for the home to meet the personal clothing needs of the residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee did not immediately report an allegation of verbal, physical and sexual abuse to the Director.
An identified resident reported that on October 28, 2011 a personal support worker spoke to the resident in an abrupt and cold manner and caused the resident pain while providing care.
The allegation was reported to the home on October 28, 2011 but the Ministry was not informed until October 31, 2011.
It was confirmed during interview that the home did not notify the Ministry immediately.
An identified resident reported an alleged incident of sexual abuse on May 3, 2012 to the Registered Practical Nurse.
The home failed to submit a mandatory report. [s. 24. (1) 2]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to the resident is immediately reported to the Director, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee did not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations. The Resident's Council Minutes & concerns reviewed for period June 2011 - June 2012 indicated:
- concern raised in July 25, 2011, Residents' Council meeting included multiple issues related to crushed medications, residents did not want them crushed; staff not aware of the menu prior to the meal; staff not checking correct texture of meal is provided to residents. The written response was dated Oct. 27, 2011. A concern that dietary staff are not marking menu changes on the board was also raised and the written response was dated Aug. 3, 2011.
- concern raised in Sept. 19, 2011, Residents' Council meeting related to missing items on the increase. The written response was dated Oct. 10, 2012
- concern raised in December 19, 2011 Residents' Council meeting related to chairs in dining room being soiled, stained and pads being worn, soiled and needing replacing. No written response within 10 days. Noted in Jan. 2012 meeting that issue had not yet been responded to.
- concern raised in May 15, 2012, Residents' Council meeting related to insufficient steam cleaners to clean wheelchairs. Written response dated May 30, 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 concerns or recommendations brought forward by the Residents' Council are responded to in writing within 10 days of receiving the concerns or recommendations, to be implemented voluntarily.

WN #8: 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 seek the advice of the Residents' Council and the Family Council in developing and carrying out the satisfaction survey.

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 in seeking the advice of the Family Council and the Residents' Council in developing and carrying out the survey, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following subsections:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee did not ensure there were measures in place to prevent the transmission of infections.
The following examples indicate measures are not in place to prevent transmission of infections:
- On June 19, 2012 at 2:21 p.m. it was observed that 4 nail clippers in a shower room were not labelled.
- On June 20, 2012 at 2:15 p.m. the following was observed on the counter in the washroom in identified residents' room: an unlabelled wash basin, denture cup and kidney basin.
- On June 20, 2012 at 4:18 p.m. the following was observed on the counter in the identified residents' washroom: upper dentures, unlabelled toothbrush & unlabelled tube of toothpaste. A slipper bedpan was on the floor under the counter.
- On June 25, 2012 at 8:00 a.m. it was observed that a registered staff administered medications including aero-chamber medications, eye drops and insulin injection to several residents without cleansing hands with alcohol hand cleanser between residents.
-On June 26, 2012 during the 12:00 p.m. medication pass it was observed that a registered staff member did not cleanse her hands between residents when administering medications which included tablets, eye drops, the administration of insulin and doing a glucometer test. Said registered staff contaminated medication when she used her hands to remove tablets from the medication pouch in order to separate the medication that needed to be crushed.
- On June 26, 2012 at 12:05 p.m. it was observed in the the tub room that nail care equipment for several residents was stored in the same plastic equipment container with no separated compartments. There was an orange unlabeled emery board in the container.

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 infection prevention and control program includes measures to prevent the transmission of infections, to be implemented voluntarily.

WN #10: 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 :

1. The licensee does not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is:
(a) in compliance with and is implemented in accordance with all applicable requirements under the Act, and
(b) complied with.
The policy and procedure for the Falls Prevention Program dated January 2011 directs the registered nurse to complete the Post Fall Assessment Tool and referral to the physiotherapy. The post fall assessment tool and the physiotherapist referral were not completed when an identified resident fell. The ADOC acknowledged the the Falls Program policies and procedures were not complied with.
2. The Falls Prevention policies & procedures (V3-360, revised March 2012) includes: post fall documentation of the initial physical assessment; completing and documenting a head to toe physical assessment at least every shift for 3 days. An identified resident who fell June 30, 2012 did not have a head to toe physical assessment completed at least every shift for 3 days. The ADOC acknowledged the the Falls Program policies and procedures had not been followed.
3. The Skin Care Program (V3-1400) directs the Direct Care Providers to complete a weekly skin assessment during the resident's first bath/shower of the week, document on the Head to Toe Skin Assessment form and report any redness, skin breakdown, skin tears, rashes, bruising, etc. to the charge nurse each shift. On June 20, 2012 the inspector observed a bruise on the identified resident's right hand. A review of the resident's health record revealed the resident, identified at high risk for falls and receiving anticoagulant therapy had a history of a recent fall. Staff reported they were not aware the resident had a bruise on the resident's right hand; the Head to Toe Skin Assessment completed by PSW staff June 17, 21, 24, 28, 2012 did not indicate the resident had a bruise on his/her right hand. On July 12, 2012 the ADOC acknowledged as per discussion with the resident that the resident had bruised his/her right hand and that an assessment had not been completed.
4. A review of the licensee's Skin Care Program, V3-1400 which includes policies and procedures for altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was not followed for an identified resident with skin tears and pressure ulcers. A review of the identified resident's health record revealed the resident had not been reassessed at least weekly by a member of the registered nursing staff, as required; a referral was not forwarded to registered dietitian for assessment, as required; the treatment administration record was not signed June 20, 2012, July 1 & 2, 2012 reflecting treatment was provided. The ADOC reported that a missing signature on the treatment administration record reflects that care was not provided and confirmed that registered staff had not provided wound & skin care in accordance with the skin care policies and procedures.
5. An identified resident exhibited altered skin integrity, specifically a rash, which required ongoing treatment since April 3, 2012, was not reassessed at least weekly by a member of the registered nursing staff, as required. The ADOC confirmed that registered staff had not completed a weekly reassessment of the resident's skin status as required.
6. The home's Continence Care policy, revised March 2012, includes completing an Annual Continence Assessment. The Annual Continence Assessment for an identified resident has not been completed since 2010. The registered nurse confirmed the resident should have had an Annual Continence Assessment in addition to the MDS assessment requirements.

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 and procedures for the required program as identified in the Act or Regulations are complied with, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following subsections:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were notified immediately upon becoming aware of several incidents of verbal abuse and an alleged incident of sexual abuse involving four residents that could potentially be detrimental to the residents' health or well-being.
The SDMs for three cognitively impaired residents were not notified of the incidents of verbal abuse exhibited towards these residents by a PSW on November 23, 2011. This was confirmed through interview with administration. At the time of this inspection the SDMs for the identified residents had not been notified.
The SDM for an identified resident was not notified of the alleged incident of sexual abuse reported to have occurred on May 2, 2012 involving an Agency nurse. This was confirmed through interview with the nurse manager.

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 each resident's substitute decision-maker, if any, and any other person specified by the resident is notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee did not ensure that the appropriate police force was immediately notified of any alleged or suspected incident of sexual abuse.
An identified resident reported to the registered practical nurse on the day shift on May 3rd, 2012 that the agency registered staff who worked the previous night shift had informed the resident he was a doctor prior to conducting a physical assessment and that during the physical assessment the agency nurse touched the resident inappropriately.

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 appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #13: 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 :

1. The licensee did not ensure a staff member was trained by a member of the registered nursing staff in the administration of topical medication.
A review of the health record for an identified resident includes a physician order for precription cream, apply twice daily until clear. PSW staff reported they apply the cream as indicated on the label and that the registered staff tell them what it is for but they have had no training in applying topical medication. The registered staff document in the treatment administration record. The Acting Director of Care confirmed that no formal training is provided to PSW staff related to the application of topical medication. [O. Reg. s. 131. (4)]
2. The licensee does not ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. On June 26, 2012 an identified resident was not administered his/her 12:00 p.m. medication as the resident was not in the dining room. At 4:00 p.m. the 12:00 p.m. medication had not been administered and remained in the medication cart.
On June 26, 2012, an identified resident was administered 30 ml. of a liquid medication. The medication order was for 50 ml three times daily. An additional 20 ml was administered to the resident after being interviewed by the inspector. [O. Reg. s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
- drugs are administered to residents in accordance with the directions for use specified by the prescriber
- the staff member has been trained by a member of the registered nursing staff in the administration of topicals, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure there is monitoring and documentation of the resident's response and effectiveness of the drug administered. Interview with DOC confirmed the home's policy that staff are supposed to document resident response and effectiveness on the back of the MAR sheet.
An identified resident was prescribed Lenotec #3, 1 tablet, every 4 hours when needed. According to the Medication Administration Record (MAR) for June 2012, the resident received the medication 11 times from June 1st to 28th, 2012 for pain. Documentation as to the effectiveness and resident's response to the pain medication was recorded 2 out of a possible 11 times.
2. A review of the MAR sheet for June 2012 noted there was no documentation regarding the resident's response and effectiveness of Tylenol 325 mg, 2 tablets administered to identified resident on June 4, 2012 for leg pain.
3. A fleet enema administered to an identified resident on June 5, 2012 did not have results documented indicating the resident's response and effectiveness.
Lactulose administered to an identified resident on June 17, 2012 did not have results documented indicating the resident's response and effectiveness.

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 when a resident is taking any drug or combination of 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, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following subsections:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee shall ensure that a registered dietitian who is member of the staff of the home completes a nutritional assessment for all residents whenever there is a significant change in health condition and assesses hydration status and any risks relating to hydration.
The registered dietitian failed to complete a nutritional assessment related to hydration status for a resident when the resident did not consume the required fluid intake for three consecutive days.
A referral to the dietitian was not completed for a resident with an identified risk for dehydration and a hydration goal of 1500 mls. (12 servings) per day when his/her fluid intake ranged from 8.5 to 11 servings for 3 consecutive days on May 28, 29 and 30, 2012 and a fluid intake which ranged between 8 to 8.5 servings on June 6, 7, and 8, 2012.
The home's Hydration Management policy directs registered staff to complete an immediate referral to the Registered Dietitian for residents at high risk for dehydration who have not consumed at least 12 servings of fluid provided at meals and snack by the home's menu for 3 consecutive days.
Through interview with the Registered Dietitian it was confirmed that referrals should have been completed but were not received for the identified resident when the resident consumed less than 12 servings for 3 consecutive days in May and June 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 each resident's hydration status and any risks relating to hydration are assessed by the dietitian, to be implemented voluntarily.

WN #16: 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 did not ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances for the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.
An identified resident, at high risk for falls, was not assessed using a clinically appropriate post-fall assessment. The Acting Director of Care confirmed that a post-fall assessment was not completed for the May 26, 2011 fall incident.

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 where the condition or circumstances of the resident requires a post fall assessment be conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following subsections:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee did not ensure that each resident of the home receives fingernail care including the cutting of fingernails.
An identified resident was observed to have dirty fingernails during the course of the inspection. On July 10, 2012 PSW staff interviewed confirmed the resident's fingernails required cleaning.

WN #18: 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 licensee did not ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the staff at the home and any changes made to the resident's plan of care relating to nutrition and hydration are implemented.
An identified resident was not referred to the registered dietitian for an assessment related to skin tears which occurred in March 2012 and reoccurred. The registered dietitian confirmed that a referral was not forwarded for the identified resident related to skin tears. [O. Reg. s. 50. (2) (b) (iii)]
2. The licensee did not ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds have been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. It was observed by inspectors on June 21, 2012, that identified resident had a rash. A review of the health record indicated that PSW staff noted the resident had a rash on March 14, 19, 26, 2012; there was no skin assessment completed by the registered staff. On April 2, 2012, it was noted the resident had a rash requiring ongoing treatment. A weekly reassessment of the resident's skin condition was completed on the following dates: April 25, May 12, May 20, June, 30, 2012. The Assistant Director of Care confirmed that registered staff had not completed a reassessment of the resident's skin as required. [O. Reg. s. 50. (2) (b) (iv)]
3. A review of the health record of an identified resident who had skin tears and prescribed treatment was not reassessed at least weekly by a member of the registered nursing staff during the period May 1 - 16, 2012. On May 29, 2012 it was noted skin treatment was provided to the resident; there was no skin assessment completed describing the status of the skin at said time. The June 2012 treatment administration record indicated the resident was provided treatment to stage 1 skin tears. There was no weekly skin assessment completed for this period. On July 2, 2012 the resident's Skin Ulcer Treatment & Assessment record noted the resident had stage 2 wounds and the treatment provided. There was no weekly wound assessment noted after July 2, 2012. The Assistant Director of Care confirmed that the registered staff had not completed a weekly skin/wound assessment as required. [O. Reg. s. 50. (2) (b) (iv)]
4. The licensee did not ensure a resident exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment instrument. The health record for an identified resident did not include a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument for skin tears in March 2012 and June 2012. This was confirmed with registered staff during an interview. [O. Reg. s.50. (2) (b) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents exhibiting altered skin integrity receive:
- a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument specifically designed for skin and wound
- an assessment 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
- a reassessment at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #19: 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 :

1. The licensee did not ensure that every medication incident involving a resident and every adverse drug reaction was:
(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 SDM, 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.
It was observed June 26, 2012 that an identified resident was not administered his/her 12:00 p.m. dose of medication. On June 27, 2012, the DOC reported she had not been informed of the medication incident. On June 29, 2012 the DOC reported the registered staff responsible for the incident failed to notify the DOC and the pharmacy; failed to document a record of the immediate actions taken to assess and maintain the resident's health.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee does not ensure that drugs remain in the original labeled container or package provided by the pharmacy service provided or the Government of Ontario until administered to a resident or destroyed.
On June 26, 2012 the 12:00 p.m. medication for an identified resident was pre- poured and not administered as the resident was not in the dining room. The medication was put in a medicine cup in the resident's bin in the medication cart and at 4:00 p.m. it was observed the medication had not been administered to the resident. The registered staff confirmed the medication was not administered as ordered and was removed from the original container.

WN #23: 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 does not ensure that drugs are stored in an area or a medication cart that is secure and locked.
On June 26, 2012 during the 12:00 p.m. medication pass in the Spruce Lane dining room registered staff was observed to leave medication and prescription eye drops unattended on top of the medication cart and accessible to residents when she left the area to obtain apple sauce. At 12:49 p.m. Tylenol #2 was left on top of the medication cart unattended and was accessible to persons entering or exiting the dining room.

WN #24: 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. 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 :

1. The licensee of the home did not ensure for each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, that there is a written description of the program that includes its:
* goals and objectives
* relevant policies, procedures, and protocols
* methods to reduce risk
* outcomes monitoring, and
* protocols for referral of residents to specialized resources where required.

The assistant director of care confirmed the home does not have a formal continence care program that includes the aforementioned required information.

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 did not ensure physical assistance or cueing to help a resident who cannot for any reason brush his or her own teeth.
An identified resident receives assistance from staff to brush and clean his/her dentures. Resident communicated that staff do not brush his/her own lower teeth. Resident's POA stated resident would have a hard time brushing his/her own teeth. Staff confirmed during interview that they do not brush the resident's teeth.
2. The licensee did not ensure that mouth care is provided in the morning and the evening including cleaning of dentures.
the identified resident wears upper dentures and has some lower teeth. Resident's POA indicates that the resident would have difficulty brushing his/her own teeth. Resident confirmed that staff do not brush his/er natural teeth. Staff providing care to resident were interviewed and confirmed they were unaware the resident has natural teeth and that they do not brush them.

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 did not ensure that the package of information to residents provided an explanation of the protections afforded by the LTCH Act 2007, section 26 - Whistle-blowing protection
The admission package did not include an explanation of whistle-blowing protection related to retaliation. [s. 78. (2) (q)]
2. The licensee did not ensure that the package of information to residents provided 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. The admission package did not include the legislative requirement to include a statement as indicated in the Long Term Care Homes Act 2007, section 78, (2) m. [s. 78. (2) (m)]

Issued on this 10th day of August, 2012

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).

Findings/Faits saillants :

1. The licensee did not ensure appropriate furnishings in resident dining areas including dining room tables at an appropriate height to meet the needs of all residents.
An identified resident was observed June 18, 2012 and throughout the inspection in an identified resident dining room in a wheelchair eating at a dining room table which is chest high for the resident. The resident was observed to have her upper extremities elevated for extended periods of time in order to feed herself due to the height of the table.

WN #25: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

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

Sharon O'Neill

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

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) :	GLORIA STILL (164), DIANE BROWN (110), LYNN PARSONS (153)
Inspection No. / No de l'inspection :	2012_103164_0017
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Date of Inspection / Date de l'inspection :	Jun 18, 19, 20, 21, 22, 25, 26, 27, 28, 29, Jul 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, 23, 24, 25, 26, 27, 2012
Licensee / Titulaire de permis :	SPENCER HOUSE INC. 835 West Ridge Blvd, ORILLIA, ON, L3V-8B3
LTC Home / Foyer de SLD :	SPENCER HOUSE INC. 835 West Ridge Blvd., ORILLIA, ON, L3V-8B3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BARBARA PIDGEN

To SPENCER HOUSE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that every alleged, suspected or witnessed incident of abuse is immediately investigated and appropriate action is taken in response to every such incident.

The plan to be submitted to Gloria.Still@ontario.ca by August 3, 2012.

Grounds / Motifs :

1. The licensee did not ensure that every alleged or suspected incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated.
The licensee failed to investigate an incident of alleged sexual abuse involving an identified resident and an agency registered nurse. The resident reported to the registered practical nurse on May 3, 2012 that on the night shift of May 2, 2012 an agency registered nurse inappropriately touched the resident during an assessment and introduced himself as a physician. The registered practical nurse reported the incident of alleged sexual abuse to the registered nurse on May 3, 2012. The registered nurse notified the licensee and agency electronically of these allegations on May 4, 2012. No further investigation was completed or additional follow-up action was taken by the licensee until it was brought to their attention by the inspector on July 10, 2012. (153)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 03, 2012

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

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. 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that 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.

The plan is to be forwarded to Gloria.Still@ontario.ca by August 10, 2012

Grounds / Motifs :

1. The licensee has failed to ensure residents admitted to the home are 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.
Twelve identified residents admitted during the period January 3, 2012- June 11, 2012 and residing in all areas of the home were not screened for tuberculosis within 14 days of admission. This information was confirmed through interview with the Infection Control Co-ordinator and registered nurse. As of July 16, 2012 the twelve identified residents had still not been screened for tuberculosis.

The plan is to be forwarded to Gloria.Still@ontario.ca by August 10, 2012 (153)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 10, 2012

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 and the

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
~~55 St. Clair Avenue West~~ 1075 Bay Street, 11th floor, Suite 1100
~~Suite 800, 8th Floor~~
Toronto, ON ~~M4V 2Y2~~ M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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~~ 1075 Bay Street, 11th Floor, Suite 1100
~~8e étage, bureau 800~~
Toronto (Ontario) ~~M4V 2Y2~~ M5S 2B1
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 27th day of July, 2012

Signature of Inspector / Signature de l'inspecteur : Gloria Still

Name of Inspector / Nom de l'inspecteur : GLORIA STILL

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