Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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
Jul 4, 5, 6, 7, 8, 11, 12, 13, 14, 15, 22, Aug 9, Sep 6, 7, 2011	2011_099188_0008	Annual

Licensee/Titulaire de permis

RIVERSIDE HEATH CARE FACILITIES, INC.
110 VICTORIA AVENUE, FORT FRANCES, ON, P9A-2B7

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

RAINYCREST
550 OSBORNE STREET, FORT FRANCES, ON, P9A-3T2

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

MELISSA CHISHOLM (188), LAUREN TENHUNEN (196), MARGOT BURNS-PROUTY (106), ROSE-MARIE FARWELL (122)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Annual inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC),the Nutrition and Food Services Manager, the Manager of Engineering and Environmental Services, the Dietitian, the Recreation and Activity Manger, the Administrative Assistant, Registered Nursing staff, Personal Support Workers (PSW), Support Services Staff, Residents and Families.

During the course of the inspection, the inspector(s) conducted a tour of the home, reviewed resident health care records, observed care and services to residents, observed meal services, reviewed various policies and procedures and various staffing patterns and schedules.

The following Inspection Protocols were used in part or in whole 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

Safe and Secure Home

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Definitions WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Définitions 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. 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 sayants :

1. Inspector observed a resident was sitting in a reclining wheelchair in the common area with a clothing protector applied an hour prior to the supper meal service. Inspector observed the same resident the sitting in the common area with the same, now soiled, clothing protector on two hours after the supper service. The licensee failed to ensure that the resident was treated with courtesy and respect. [LTCHA, 2007, S.O. 2007, c.8, s.3(1)(1)]
2. Inspector observed on a resident was in the common area sitting in a reclining wheelchair with a clothing protector on a hour after breakfast service was completed. Inspector observed that this same resident remains in the wheelchair in the common area with the same clothing protector on 2 hours after the previous observation (now 3 hours after meal service). The licensee failed to ensure that the resident was treated with courtesy and respect. [LTCHA, 2007, S.O. 2007, c.8, s.3(1)(1)]

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

Specifically failed to comply with the following 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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 sayants :

1. Inspector interviewed a resident related to food preferences. The resident identified a food preference. Inspector interviewed a dietary aid on who confirmed resident's food preference. Inspector reviewed the plan of care for this resident which does not identify the resident's food preference. The licensee failed to ensure that the plan of care is based on an assessment of the resident's needs and preferences. [LTCHA, 2007, S.O. 2007, c.8, s.6.(2)]
2. Inspector interviewed restorative therapy staff and a PSW who reported that a resident no longer uses the splint/brace. Inspector reviewed the care plan which listed the use of the splint/brace. The licensee failed to review and revise the plan of care for this resident when the care set out in the plan of care is no longer necessary. [LTCHA, 2007, S.O. 2007, c.8, s.6.(10)(b)].
3. Inspector interviewed a PSW regarding a resident's oral care. The PSW identified the resident requires staff assistance. The inspector reviewed the resident's assessment in MDS which identified that the resident requires minimal assistance with ADL's including mouthcare and that the resident was resistive to care. Inspector reviewed the resident's plan of care and noted it did not provide any direction to staff regarding the resident's oral care needs. The licensee 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. [LTCHA, 2007, S.O. 2007, c.8, s.6(10)(b)]
4. Inspector reviewed the health care record for a resident. Inspector noted a physicians order to discontinue oxygen use. Inspector reviewed the plan of care for this resident which identifies the use of oxygen. The licensee failed to review and revise the plan of care for this resident when the care set out in the plan of care is no longer necessary. [LTCHA, 2007, S.O. 2007, c.8. s.6(10)(b)]
5. During an interview of two PSWs on July 14, 2011, both staff members stated that a resident does not have dentures. The plan of care identifies that the resident does have dentures and staff are to assist with application of the dentures. The licensee failed to ensure staff are kept aware of the contents of the resident's plan of care. [LTCHA, 2007, S.O. 2007, c.8, s.6(8)]
6. Inspector reviewed the plan of care for a resident which identifies specific interventions related to falls prevention. Inspector observed on two occasions that these interventions were not being followed. The licensee failed to ensure care set out in the plan of care related to falls prevention was provided as specified in the plan. [LTCHA, 2007, S.O. 2007, c.8, s.6(7)]
7. During an interview with the inspector, two PSWs identified specific interventions related to oral care for a resident. Upon review, the inspector noted these interventions are not listed in the plan of care. The licensee failed to ensure the care set out in the plan of care is provided as specified in the plan. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)]
8. Inspector noted the kardex page for a resident, found in the section binder, identifies this resident as requiring set up only for transfers. The MDS assessment indicates that this resident transfers independently. During a staff interview a PSW identified to the inspector that this resident is a two-person transfer and on occasion requires the sit to stand lift. The PSW also identified that this resident has specific interventions related to fall prevention. The resident's plan of care does not contain reference to these interventions. The licensee failed to ensure the written plan of care sets out clear directions to staff and others who provide direct care to the resident. [LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(c)]
9. The plan of care related to risk of injury from falls for a resident, includes the intervention: provide appropriate ambulation aids and/or supervision to steady the resident's gait as much as possible. This does not provide clear direction to staff as to what ambulation aids are to be used with this resident. The licensee failed to ensure the plan of care does sets out clear directions to staff and others who provide direct care to the resident. [LTCHA, 2007, S.O. 2007, c.8, s.6(1)(c)]
10. Inspector reviewed the home's Bowel Movements/Routines. It identifies that a resident who has gone three days without a bowel elimination will receive Milk of Magnesia (MOM) 30mls at 08:00h on day three. If the resident has not had a bowel elimination on day four the resident will receive a suppository at 10:00h on day four. If the resident has not had a bowel elimination on day five, the resident will receive a fleet enema or a soap suds enema per rectum on day five. Inspector reviewed the health care record for a resident as related to bowel elimination. The inspector noted that the resident went seven days without a bowel elimination and the bowel protocol was not followed. The licensee failed to ensure care was provided as specified in the plan. [LTCHA, 2007, S.O. 2007, c.8, s.6(7)]
11. The inspector reviewed a resident's health care record related to nutrition and noted the resident had experienced recent weight loss. During the supper meal service of July 13, 2011, the resident was observed to have completed 100% of the meal. A PSW who was assisting the resident, was interviewed and reported that the resident's appetite was good, and that the resident has specific food likes and dislikes. The inspector reviewed the resident's plan of care and noted that information regarding the resident's preferences were not identified in the resident's nutritional plan of care. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident [LTCHA, 2007, S.O. 2007, c.8, 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 ensuring 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 residents, that staff are kept aware of the contents of the resident's plan of care and that the care is provided to the residents as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 10. Recreational and social activities
Specifically failed to comply with the following subsections:

s. 10. (2) Without restricting the generality of subsection (1), the program shall include services for residents with cognitive impairments, and residents who are unable to leave their rooms. 2007, c. 8, s. 10 (2).

Findings/Faits sayants :

1. Inspector reviewed a resident's Activation Quarterly Assessment. The assessment identified the resident participates in activities but requires staff assistance to attend and the resident is cognitively impaired. The Activities Coordinator, was interviewed by the Inspector, regarding this resident's participation in services for residents with cognitive impairments. It was identified that this resident is brought to general large group activities such as sing alongs and dances. Even though the resident cannot actively participate, the Coordinator believes the resident passively participates. This resident is not included in services for residents with cognitive impairments; delivered exclusively on the Special Care Unit, because the resident does not reside on the unit.
Inspector interviewed a PSW who reported that they had not observed this resident participate in any activities other than watching movies due to the resident's cognitive status. Inspector made multiple observations of this resident's participation in social/recreational activities. Inspector noted that the resident's sole recreational or social activity was limited to being positioned in front of the TV in the common area. The licensee failed to ensure that services for residents with cognitive impairments were provided.[LTCHA 2007, S. O., 2007, c.8, s. 10 (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 ensuring the organized program of recreational and social activities includes services for [redacted] and all residents with cognitive impairments, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services
Specifically failed to comply with the following subsections:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits sayants :

1. Inspector observed on in a room that the privacy curtain had a brown substance smeared along the edge of the curtain. Two other areas on the same privacy curtain was noted to be soiled. The licensee has failed to ensure that the furnishings are kept clean and sanitary. [LTCHA 2007, S.O. 2007, c.8, s.15.(2)(a)]
2. Inspector observed in a room that the flooring, previously repaired, is lifting and no longer properly adhered. The licensee failed to ensure the home is maintained in a safe condition and good state of repair. [LTCHA, 2007, S.O. 2007, c.8, s.15(2)(c)]
3. Inspector observed a hole in the lower wall approximately 15 cm in length by 10 cm in height near the bathroom door in a room. Inspector noted that the paint is chipped on the door frame of the bathroom. The resident reported to inspector that it has been that way "since forever". The licensee failed to ensure the home is maintained in a good state of repair. [LTCHA 2007, S.O. 2007, c.8. s.15(2)(c)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance
Specifically failed to comply with the following subsections:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits sayants :

1. Inspector reviewed the home's abuse policy RCS A-15. The policy does not contain an explanation of the duty under section 24 of the Act to make mandatory reports and does not set out the consequences for those who abuse or neglect residents. The licensee failed to ensure their written policy includes the required information. [LTCHA 2007, S.O. 2007, c.8, s.20(2)]

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

1. The licensee does not respond in writing within 10 day of receiving Residents' Council advice related to concerns or recommendations. During an interview the Resident Council President stated that the home does not respond in writing within 10 days of receiving their concerns. During an interview with the residents council assistant identified that the home responds verbally to concerns brought up in meetings within ten days but could not confirm that they always respond in writing within 10 days.[LTCHA, 2007, S.O. 2007, c.8, s.57(2)]

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 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 sayants :

1. Inspector reviewed the home's Bowel Movements/Routines. It identifies that a resident who has gone three days without a bowel elimination will receive Milk of Magnesia (MOM) 30mls at 08:00h on day three. If the resident has not had a bowel elimination on day four the resident will receive a suppository at 10:00h on day four. If the resident has not had a bowel elimination on day five, the resident will receive a fleet enema or a soap suds enema per rectum on day five. Inspector reviewed the health care record for a resident as related to bowel elimination. The inspector noted that the resident went seven days without a bowel elimination. This resident did not receive interventions as outlined in the bowel elimination protocol. The licensee failed to ensure their policy was complied with. [O.Reg. 79/10, s.8(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 ensuring any plan, policy, protocol, procedure, strategy or system required under the Act is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following subsections:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits sayants :

1. Residents were not offered planned menu items during the lunch service on July 4 and 12, 2011. On July 4, 2011 the strawberry jello that was posted as a dessert was not available and vanilla pudding/or mouse was served in the Morrison dining room instead. On July 12, 2011, in the main dining room and the Morrison dining room, the chicken salad sandwich that was posted as a lunch choice was not available to residents and ham salad was served instead. [O. Reg. 79/10, s.71(4)]
2. During an interview with the food services manager it was identified that during a period of six weeks in May and June both steamers in the kitchen were not working. During this time substitutions of the vegetable choices were made and the planned menu vegetable choice was not offered to residents. The licensee failed to ensure the planned menu items are offered and available at each meal and snack. [O. Reg. 79/10, s.71(4)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following subsections:

s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;
(c) standardized recipes and production sheets for all menus;
(d) preparation of all menu items according to the planned menu;
(e) menu substitutions that are comparable to the planned menu;
(f) communication to residents and staff of any menu substitutions; and
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Findings/Faits sayants :

1. The licensee failed to ensure that all menu substitutions are communicated to residents and staff. During a six week period in May and June when both steamers in the kitchen were not working substitutions to the menu were made, the Nutrition and Food Services Manager was unable to verify that the substitutions were communicated to the residents each time a substitution was made.[O.Reg. 79/10, s.72(2)f]
2.On July 4, 2011, during the lunch meal service, vanilla pudding/mouse was substituted for the planned menu item of strawberry jello, this substitution was not communicated to residents. The daily menu posted outside the main dining room stated that strawberry jello was one of the dessert selections. [O.Reg. 79/10, s.72(2)f]
3. On July 12, 2011, ham salad sandwiches were served to residents. The planned and posted menu item was chicken salad sandwiches. This substitution was not communicated to staff and residents in the Morrision dining. When the dietary aid was asked by the inspector what was served the dietary aid said, "chicken salad sandwiches, that is what it says on the menu". The menu substitution was not communicated to residents and staff. [O. Reg. 79/10, s.72(2)(f)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian
Specifically failed to comply with the following subsections:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits sayants :

1. Inspector spoke with the Nutrition and Food Services Manager (NFSM) on July 14, 2011. The NFSM identified that the dietitian is not meeting the required amount of hours at this time. It was reported to the inspector that the dietitian is currently working 10.25 hours a month. The required number for hours for the dietitian within the home would be 20.5 hours a month based on the number of resident in the home. The NFSM identified that the home is in the process of hiring a second dietitian, however no qualified candidates have yet been found. The licensee failed to ensure a dietitian, who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month.

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 ensuring that a registered dietitian who is a member of the staff of the home is on site and the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties , to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system
Specifically failed to comply with the following subsections:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits sayants :

1. On July 13, 2011 the Inspector reviewed the licensee's Administration of Medication – One-time sign in for Medication Policy and the Controlled and Narcotic Drugs Policy and noted that the 2 policies contained conflicting directions.

The Administration of Medication (One time sign in for Medication) Policy; Procedure 10 states, "regularly scheduled medications such as Narcotics, Coumadin, Antibiotics and Prednisone are included in the one-time signature, if they are contained in the Medi Pak; where as, Procedures 4 and 7 of the Controlled and Narcotic Drugs Policy state that Registered staff (4) "Initiates an "individual narcotic record" with the resident's name, the drug name, and strength/dosage, and indicates the amount received from pharmacy and (7) "After administering narcotics, signs the Individual Narcotic Record for the resident in question, indicating the date, time, dosage administered and the remaining amount."

The licensee failed to ensure that written policies and protocols were developed, implemented, evaluated and updated in accordance with evidence based practices and, if there are none, in accordance with prevailing practices [LTCHA 2007, O. Reg. 79/10, s.114 (3)]

2. The licensee's Controlled and Narcotic Drugs Policy Summary states "all narcotics drugs are stored under a double locking system at all times".

On July 13, 2011 the Inspector observed an RPN conduct the medication pass. The RPN reviewed a resident's Medi Pak card with the Inspector and identified that the resident would receive a controlled substance. Inspector observed the resident's Medi Pak card and noted 4 tablets of the controlled substance remained in the Medi Pak. The inspector reviewed the physician's orders and the MAR and confirmed that the white tablets were a controlled substance ordered for that resident.
The RPN reported that narcotics which were administered to residents on a regular basis were supplied in the same Medi Pak as non narcotic medications and stored in the same drawers of the medication cart as non narcotic medication. Further, the RPN reported that residents, who were ordered narcotic medications on a prn basis, were supplied with medication cards which contained narcotics exclusively. Further, the RPN reviewed the narcotic shift count and individual narcotic administration records. The RPN reported that an individual narcotic record was only initiated for residents who received narcotic medications on a prn basis and who were supplied with a medication card which exclusively contained that narcotic drug. Narcotics administered on a regular basis were not counted. The medication cards which contained narcotic medications exclusively were stored in the separate locked cabinet of the medication cart, whereas, narcotic medications supplied in the same Medi Pak cards as non narcotic medications were not stored in the separate locked cabinet of the medication cart.

The licensee failed to ensure that written policies and protocols developed for the medication management system were implemented. [O.Reg. 79/10, s.114(3)a]

3.Inspector reviewed the home's policy titled "ADMINISTRATION OF MEDICATION, One-time sign in for Medication". Under a Note section, the policy identifies the following, "Liquids, powders, eye drops, nasal sprays, patches, treatments, medication received from secondary or back up pharmacy etc. require individual signatures in the appropriate boxes". Inspector reviewed the Medication Administration Record (MAR) for a resident, for the month of July 2011, and noted no individual signatures for two regularly scheduled creams. The licensee failed to ensure their policy titled "ADMINISTRATION OF MEDICATION One-time sign in for Medication" was complied with. [O.Reg. 79/10, s.114(3)a]

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 ensuring that policies and procedures related to the medication management system are implemented, to be implemented voluntarily.

WN #12: 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 sayants :

1. On July 13, 2011 the Inspector observed an RPN conduct the medication pass. The RPN reviewed resident's Medi Pak card with the Inspector and identified that the resident would receive a controlled medication. Inspector observed the resident's Medi Pak card and noted this controlled medication remained in the blister pack for administration during the HS medication pass. In addition, the inspector reviewed the physician's orders and the MAR and confirmed that the white tablets were a controlled substance.
The RPN reported that narcotics which were administered to residents on a regular basis were supplied in the same Medi Pak as non narcotic medications and stored in the same drawers of the medication cart as non narcotic medication. Further, the RPN reported that residents, who were ordered narcotic medications on a prn basis, were supplied with medication cards which contained narcotics exclusively. These narcotic medication cards were stored in the separate locked cabinet of the medication cart. The licensee failed to ensure that controlled substances are stored in a separate locked area within the medication cart. [O.Reg. 79/10, s. 129(1)b]
2. During an interview with the inspector, two RPNs, reported that regularly scheduled Tylenol #3 is not stored in a separate locked area within the locked medication cart. The RPNs confirmed that lorazepam, serax, and other benzodiazepines are not kept in a separate locked area within the locked medication cart. [O.Reg. 79/10 s.129(1)(b)]
3. Inspector observed on July 14, 2011 that the following medications were not stored in a separate locked area with the locked medication cart. Lorazepam, Tylenol #2 and Oxazepam. The licensee failed to ensure that controlled substances are stored in a separate locked area within the locked medication cart.[O.Reg. 79/10 s.129(1)(b)]
4. Inspector observed on July 12, 2011, that a resident's regularly dosed controlled substance is kept along with all other regularly scheduled medications within the weekly medication blister pack and is not stored in a separate locked area within the locked medication cart. [O.Reg. 79/10, s.129(1)(b)]
5. The licensee does not ensure that controlled substances are stored in a separate locked area with in the locked medication cart. An RN stated that if a controlled substance such as Tylenol 2 or 3 are part of the resident's regular drug regimen they will be included in the resident's blister pack and are kept with the regular (non-controlled medications) and not in the separate locked area in the locked medication cart. [O.Reg. 79/10 s.129(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 ensuring 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, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits sayants :

1. On July 12, 2011 a RN reported to the inspector that the Ward Clerk had the keys to government stock room. The DOC confirmed that the Ward Clerk has the keys for the government stock and is responsible for monthly counts and ordering. Registered staff "know where the keys are" after hours and weekends. The licensee failed to ensure that areas where drugs are stored are restricted to those who may dispense, prescribe or administer drugs in the home and the Administrator. [O.Reg. 79/10, s.130(2)]
2. Inspector interviewed two separate registered staff members who both confirmed that the ward clerk has access to and regularly stocked the medication storage areas. The licensee failed to ensure that areas where drugs are stored are restricted to those who may dispense, prescribe or administer drugs in the home and the Administrator. [O.Reg. 79/10, s.130(2)]

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.

Specifically failed to comply with the following subsections:

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

Findings/Faits sayants :

1. Inspector reviewed a resident's health care record. Inspector noted that the last documented quarterly review of the residents drug regime was completed four months prior. The licensee failed to ensure that there is a documented reassessment of each resident's drug regime at least quarterly. [O. Reg. 79/10, s.134(c)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home
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 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.
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents.
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9.

Findings/Faits sayants :

1. Inspector observed, on July 14, 2011, that the dead bolt lock on the following five bedroom doors can be engaged from inside the room: E86, W43, W47, W49, W56. These locks require a separate key which is in possession of the float RN (who provides coverage for the entire building) to disengage the lock from the outside of the room. The licensee failed to ensure that any locks on bedroom doors must be designed and maintained so they can be readily released from the outside in an emergency. [O.Reg. 79/10, s.9(3)]

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 ensuring any locks on bedroom doors must be designed and maintained so they can be readily released from the outside in an emergency, to be implemented voluntarily.

WN #16: 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. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits sayants :

1. A PSW was interviewed by the inspector regarding a resident's oral care. The PSW identified to the inspector the resident's oral care needs. The inspector reviewed the MDS assessment for the resident which also identifies the need for oral care by staff. Inspector reviewed the resident's plan of care and noted that it does not provide any direction to staff regarding the resident's oral care needs.The licensee failed to ensure that the resident's plan of care includes dental and oral status including oral hygiene. [O.Reg 79/10, s.26(3)12]
2. Inspector reviewed continence assessment in the MDS for a resident. The assessment identifies this resident as occasionally incontinent of bladder and continent of bowel. Inspector reviewed the plan of care for this resident which identifies the occasional bladder incontinence. The plan of care does not include any information regarding the resident's bowel elimination. The licensee failed to ensure the plan of care includes the resident's bowel elimination. [O.Reg. 79/10, s.26(3)(8)]
3. Inspector reviewed health care record for a resident. The MDS assessment identifies the resident has dentures or removable bridge and daily cleaning of teeth/dentures by resident or staff. Inspector noted that the plan of care for this resident does not provide any direction regarding oral health. The plan of care does not identify this resident as having dentures or specify who is to provide mouth care. The licensee failed to ensure the plan of care is based on an interdisciplinary assessment of the resident's dental and oral status. [O.Reg. 79/10 s.26(3)12]

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 ensuring the plan of care for all residents in the home is based on interdisciplinary assessment of the identified areas, to be implemented voluntarily.

WN #17: 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. (2) The licensee shall ensure that each resident receives assistance, if required, to insert dentures prior to meals and at any other time as requested by the resident or required by the resident's plan of care. O. Reg. 79/10, s. 34 (2).

Findings/Faits sayants :

1. Inspector observed that two residents did not have their dentures inserted for breakfast and lunch on both July 13 and 14, 2011. The dentures remained in denture cups in the resident's bathroom. The licensee failed to ensure these two residents receive assistance to insert dentures prior to meals. [O.Reg. 79/10 s.34(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 ensuring each resident receives assistance to insert dentures prior to meals, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids
Specifically failed to comply with the following subsections:

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

Findings/Faits sayants :

1. Inspector observed, on July 6, 2011, on the Specialty Care Unit the following unlabeled personal items.
- In room W29, an unlabeled wash basin, denture cup and tooth brush, noted in the resident's washroom,
- In room W25, an unlabeled tooth brush, denture cup and wash basin, noted in the resident's washroom
- In room W24, an unlabeled toothbrush and wash basin, noted in the resident's washroom, noted in the resident's washroom
- In room W14, three unlabeled tooth brushes.

The licensee failed to ensure that each resident of the home has his or her personal items labeled.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following subsections:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits sayants :

1. Inspector interviewed the DOC on July 14, 2011. It was identified that currently the home is in development of a pain management program and currently no pain management program is implemented in the home. The licensee failed to ensure a pain management program is developed and implemented in the home. [O.Reg. 79/10 s.48(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 developing and implementing a pain management program within the home, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following subsections:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
1. Treatments and interventions to promote continence.
2. Treatments and interventions to prevent constipation, including nutrition and hydration protocols.
3. Toileting programs, including protocols for bowel management.
4. Strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aids.
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;
(e) continence care products are not used as an alternative to providing assistance to a person to toilet;
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits sayants :

1. Inspector reviewed the plan of care for a resident related to incontinence. Inspector noted that the care plan identifies under the section for urinary incontinence "toilet regularly" as an intervention, no further individualized plan or routine is identified for this resident in relation to managing incontinence. During an interview with this resident's PSW it was identified that no individualized toileting plan is followed for the resident to promote bladder continence. The licensee failed to ensure a resident who is incontinent has an individualized plan of care to promote and manage bowel and bladder continence and that plan is implemented. [O.Reg. 79/10, s.51(2)(b)]
2. Inspector reviewed assessments for a resident. Inspector noted that the MDS assessment identifies this resident as incontinent of bladder. This was confirmed by the resident's PSW during an interview. Inspector noted that specific interventions are not identified in an assessment or the plan of care for this resident. The licensee failed to ensure this resident, who is incontinent, has an assessment that includes the potential to restore function with specific interventions. [O.Reg. 79/10 s.51(2)(a)]
3. The inspector reviewed a resident's nutritional assessment in MDS, which identified that the resident was prone to constipation. The inspector reviewed the residents bowel movement/routine record for the month of June 2011 and it was noted that the resident had suffered episodes of constipation. The inspector reviewed resident dietary quarterly assessment by the Registered Dietitian. The inspector reviewed the nutritional plan of care and noted that it did not contain any information regarding the prevention of constipation utilizing dietary measures. The licensee failed to ensure that the continence care and bowel management program provided treatments and interventions to prevent constipation including nutrition and hydration protocols. [O.Reg. s.51(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 ensuring each resident who is incontinent has an individualized plan and that plan is implemented, to be implemented voluntarily.

WN #21: 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 sayants :

1. During a July 14, 2011, discussion with the DOC she stated that residents who were admitted prior to March 2011 would not have been screened to ensure they have been offered or received the tetanus and diptheria vaccine. [O. Reg. 79/10, s.229(10) 3]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following subsections:

s. 241. (7) The licensee shall,
(a) provide a resident, or a person acting on behalf of a resident, with a written receipt for all money received by the licensee from the resident, or any other person, for deposit in a trust account on behalf of the resident;
(b) where the licensee has deposited in a trust account money received from any person on behalf of a resident, make part or all of the money available to the resident or a person acting on behalf of the resident,
(i) in accordance with the instructions of the resident or a person acting on behalf of the resident in respect of the property the resident or the person is legally authorized to manage, and
(ii) upon the resident, or the person acting on behalf of the resident, signing an acknowledgement that the resident, or the person acting on behalf of the resident, received the funds;
(c) maintain a separate ledger for each trust account showing all deposits to and withdrawals from the trust account, the name of the resident for whom the deposit or withdrawal is made and the date of each deposit or withdrawal;
(d) maintain a separate book of account for each resident for whom money is deposited in a trust account;
(e) on the written demand of a resident, or a person acting on behalf of a resident, make the residents' book of account referred to in clause (d) available for inspection by the resident or the person during any business day;
(f) provide to the resident, or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement; and
(g) with respect to each resident for whom money is deposited in a trust account, retain for a period of not less than seven years,
(i) the books of account, ledgers, deposit books, deposit slips, pass-books, monthly bank statements, cheque books and cancelled cheques applicable to the trust account,
(ii) the written instructions and authorizations and acknowledgements of receipt of funds of the resident and the person acting on behalf of the resident, and
(iii) the written receipts and statements provided to the resident, or a person acting on behalf of a resident. O. Reg. 79/10, s. 241 (7).

Findings/Faits sayants :

1. Inspector interviewed a resident. The resident identified to the inspector that the resident does not receive a quarterly itemized written statement including deposits and withdrawals and the balance of the comfort fund (trust fund). The resident identified a statement is received only when requested at the front office. The Administrative Assistant confirm to the inspector that quarterly statements are not provided to residents unless specifically requested by the resident. The licensee failed to ensure that each resident is provided with a quarterly itemized written statement including deposits and withdrawals and the balance of the resident's fund. [O.Reg. 79/10 s.241(7)(f)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 261. Statements

Specifically failed to comply with the following subsections:

s. 261. (1) Every licensee of a long-term care home shall, within 30 days after the end of each month, provide each resident or the resident's attorney under the Powers of Attorney Act, or person exercising a continuing power of attorney for property or a guardian of property under Part I of the Substitute Decisions Act, 1992, with an itemized statement of the charges made to the resident within the month. O. Reg. 79/10, s. 261 (1).

Findings/Faits sayants :

1. Inspector interviewed a resident. The resident identified to the inspector that the resident does not receive a monthly statement of charges made, including the monthly accommodation charge. The resident identified that an annual statement identifying the amount paid for the year is received. The Administrative Assistant confirmed to the inspector, that monthly statements are not provided to residents unless specifically requested by the resident. The licensee failed to ensure that each resident is provided with a monthly itemized statement of the charges made to the resident within the month. [O.Reg. 79/10 s.261(1)]

WN #24: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information
Specifically failed to comply with the following subsections:

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

Findings/Faits sayants :

1. Inspector observed, during a tour of the home on July 14, 2011, that there was no explanation of evacuation procedures posted or communicated in a conspicuous area. The licensee failed to post or communicate an explanation of evacuation procedures. [LTCHA 2007, S.O. 2007, s.79.(3)(j)].
2. Inspector observed, during a tour of the home on July 14, 2011, that the homes' policy to minimize the restraining of residents was not posted. The licensee failed to post and communicate the policy to minimize the restraining of residents as well as information about how a copy of the policy could be obtained. [LTCHA 2007, S.O. 2007, s. 79.(3)(g)].
3. Inspector observed, during a tour of the home on July 14, 2011, that the policy to promote zero tolerance of abuse and neglect of residents was not posted in a conspicuous area. The licensee has failed to post the policy to promote zero tolerance of abuse and neglect of residents. [LTCHA 2007, S.O. 2007, c.8, s. 79.(3)(c)].

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services
Specifically failed to comply with the following subsections:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits sayants :

1. Inspector interviewed the Manager Engineering and Environmental Services (MEES) on July 14, 2011. The MEES reported to inspector that the home does not have a routine, preventive maintenance program. The licensee failed to ensure that there are schedules and procedures in place for routine, preventive and remedial maintenance. [O.Reg. 79/10, s. 90.(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 ensuring that the home develops and implements schedules and procedures for routine, preventive and remedial maintenance, to be implemented voluntarily.

Issued on this 7th day of September, 2011

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