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) :	MELISSA CHISHOLM (188), KELLY-JEAN SCHIENBEIN (158), MONIQUE BERGER (151)
Inspection No. / No de l'inspection :	2013_099188_0015
Log No. / Registre no:	S-000004-13
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 19, 2013
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH CENTRE OF SUDBURY 1140 South Bay Road, SUDBURY, ON, P3E-0B6
LTC Home / Foyer de SLD :	ST.GABRIEL'S VILLA OF SUDBURY 4690 Municipal Road 15, , Chelmsford, ON, P0M-1L0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jo-Anne Palkovits

To ST. JOSEPH'S HEALTH CENTRE OF SUDBURY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure the written plan of care for residents #1493, #1494, #1516, #1549 sets out clear directions to staff and others who provide direct care to the resident.

Grounds / Motifs :

1. Inspector was informed by staff #S100 that resident #1549 has ongoing pain. Staff #S100 further explained that the resident often requests cream to be applied and this is an effective treatment used to relieve the pain. Inspector noted multiple progress notes confirming the resident's request for, and the application of cream. Inspector noted this intervention is not reflected within the resident's plan of care and there is no direction to staff regarding the application of cream. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. (188)

2. Inspector reviewed resident #1516's health care records and interviewed staff in regards to responsive behaviours demonstrated by the resident. Inspector noted the resident displayed responsive behaviours. Inspector reviewed the resident's most recent plan of care and could find no focus or related interventions for the responsive behaviours. The licensee failed to ensure that plan of care sets out clear direction to staff and others who provide direct care to staff. (151)

3. Inspector reviewed resident #1516's health care record noting the resident

had experienced multiple falls. Inspector interviewed staff in relation to the falls. Health records and staff interviews confirm the resident requires the use of a walker because of an existing gait and balance problem. The gait and balance issues are further compounded when the resident has pain. Staff interviewed stated that when they observe the resident experiencing pain they provide the resident with a wheelchair because of the increased risk of falls. Inspector reviewed the resident's plan of care and could find no focus addressing falls prevention and management, further the plan of care failed to identify the staff stated interventions of the provision of a wheelchair when the resident was experiencing pain. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. (151)

4. Resident #1493 plan of care was reviewed and there was no direction related to nail cutting. On May 14, 2013, inspector 151 observed that resident's #1493 fingernails were long, jagged and have accumulated debris. Inspector 158 observed that resident's #1493 fingernails were long and jagged on May 16, 17, and 22, 2013. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to resident. (158)

5. Inspector reviewed the plan of care for resident #1493. Inspector noted the plan of care did not address the resident's medical condition or provide any direction related to treatment for this condition. The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident. (158)

6. Inspector reviewed the plan of care for resident #1494 noting pain is identified with the administration of a pain medication as an intervention. The resident stated to the inspector on May 14 and 21, 2013 that the mattress is uncomfortable and therefore is unable to sleep on it as it causes increased pain, this is further supported by documentation within the resident's progress notes which identify the resident has been sleeping in a Lazy-Boy chair. Inspector noted the plan of care provided no direction related to the resident's pain as it relates to the discomfort associated with the mattress. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident. (158)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 05, 2013

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to residents #1493, #1494, #1523, as specified in their plan.

Grounds / Motifs :

1. Inspector observed that resident #1493's has a contraction. The physiotherapist assessed resident #1493 and identified specific interventions. Resident #1493 plan of care does identify these interventions, however, they were not observed to be implemented by inspector 151 or 158 during this inspection. The licensee failed to ensure the care was provided to the resident as specified in the plan. (158)

2. Inspector reviewed the health care records for resident #1523 and noted the plan of care identified the resident was to be offered the sensory room activity 1-2 times per week. Inspector reviewed the residents activation participation flow sheets for the last 3 months and noted that there is no documentation to support that the resident had received the sensory room activity. In an interview, the Life Enrichment Aide assigned to the unit confirmed that the resident had not been to the sensory room for a very long time. In addition, the plan of care directs that the resident is to participate in 2 activities per week. Review of the resident's activation participation records shows that in March 2013, resident received a total of 4 activities with no activities documented between March 1, 2013 and March 21, 2013. In reference to the April 2013 record, resident received a total of 6 activities. The licensee failed to ensure that the care was provided to the resident as specified in the plan. (151)

3. Resident #1494 has had a history of falls. The plan of care identified as a fall

prevention strategy to ensure a tabs monitor is attached to resident garments and is attached to call bell system. On May 23, 2013, the inspector observed that the tabs monitor was on the resident's bed and not attached to the resident's garments from 08:30h to 15:30hr. The tabs monitor was observed attached to the wheelchair and clothing at 16:30h. The licensee failed to ensure that the care was provided to the resident as specified in the plan. (158)

4. The inspector reviewed the health care record for resident #1493 on May 23, 2013. It is documented in the resident's plan of care that staff are to provide frequent 1-1 visits 1-2xs a week for social interaction. The flow sheets for the provision of activities, identified that the resident attended one activity in the past two months, further, 1:1 visits were not observed or documented as being provided in May 2013. The licensee failed to ensure that the care was provided to the resident as specified in the plan. (158)

5. Inspector noted the plan of care for resident #1494 identifies that the resident is to be monitored for increased evidence of coughing and choking. It was documented on the point of care that 175ml of fluid was taken at 10:37h on May 21, 2013 however the inspector observed resident #1494 was sleeping at this time. The thickened water was placed on the resident's bedside table and no assistance or monitoring of the resident was provided. The inspector observed that the level of water was unchanged at 11:30h. The licensee failed to ensure the care was provided to the resident as specified in the plan. (158)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 05, 2013

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
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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 Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
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.

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
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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.

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

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
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 19th day of June, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : MELISSA CHISHOLM

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 19, 2013	2013_099188_0015	S-000004-13	Resident Quality Inspection

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH CENTRE OF SUDBURY
1140 South Bay Road, SUDBURY, ON, P3E-0B6

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

ST.GABRIEL'S VILLA OF SUDBURY
4690 Municipal Road 15, , Chelmsford, ON, P0M-1L0

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

MELISSA CHISHOLM (188), KELLY-JEAN SCHIENBEIN (158), MONIQUE BERGER (151)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 13-17, 21-24, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Acting Coordinator for the Infection Control Program, Environmental Services Manager, the Food Service Supervisor, the Dietitian, Physiotherapy Aides, the Admissions Coordinator, the Program Coordinator for Activity and Therapy, Scheduling Clerks, Housekeeping Aides, Activation Aides, Dietary Aides, Chair person for Resident Council, Chair person for Family Council, the Social Worker, the Chaplain/Pastoral Care Worker, Registered Nurses, Registered Practical Nurses, Personal Support Workers (known in the home as PCA - Personal Care Assistant), residents, families and volunteers.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions, reviewed resident health care records, reviewed various policies and procedures and observed meal service.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Admission Process
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality

Hospitalization and Death
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Reporting and Complaints
Resident Charges
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. Inspector reviewed the plan of care for resident #1494 noting pain is identified with the administration of a pain medication as an intervention. The resident stated to the inspector on May 14 and 21, 2013 that the mattress is uncomfortable and therefore is unable to sleep on it as it causes increased pain, this is further supported by documentation within the resident's progress notes which identify the resident has been sleeping in a Lazy-Boy chair. Inspector noted the plan of care provided no direction related to the resident's pain as it relates to the discomfort associated with the mattress. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. Inspector reviewed the plan of care for resident #1493. Inspector noted the plan of care did not address the resident's medical condition or provide any direction related to treatment for this condition. The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. Resident #1493 plan of care was reviewed and there was no direction related to nail cutting. On May 14, 2013, inspector 151 observed that resident's #1493 fingernails were long, jagged and have accumulated debris. Inspector 158 observed that resident's #1493 fingernails were long and jagged on May 16, 17, and 22, 2013. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to resident. [s. 6. (1) (c)]

4. Inspector reviewed resident #1516's health care record noting the resident had experienced multiple falls. Inspector interviewed staff in relation to the falls. Health records and staff interviews confirm the resident requires the use of a walker because of an existing gait and balance problem. The gait and balance issues are further compounded when the resident has pain. Staff interviewed stated that when they observe the resident experiencing pain they provide the resident with a wheelchair because of the increased risk of falls. Inspector reviewed the resident's plan of care and could find no focus addressing falls prevention and management, further the plan of care failed to identify the staff stated interventions of the provision of a wheelchair when the resident was experiencing pain. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

5. Inspector reviewed resident #1516's health care records and interviewed staff in regards to responsive behaviours demonstrated by the resident. Inspector noted the

resident displayed responsive behaviours. Inspector reviewed the resident's most recent plan of care and could find no focus or related interventions for the responsive behaviours. The licensee failed to ensure that plan of care sets out clear direction to staff and others who provide direct care to staff. [s. 6. (1) (c)]

6. Inspector was informed by staff #S100 that resident #1549 has ongoing pain. Staff #S100 further explained that the resident often requests cream to be applied and this is an effective treatment used to relieve the pain. Inspector noted multiple progress notes confirming the resident's request for, and the application of cream. Inspector noted this intervention is not reflected within the resident's plan of care and there is no direction to staff regarding the application of cream. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

7. Inspector noted the plan of care for resident #1494 identifies that the resident is to be monitored for increased evidence of coughing and choking. It was documented on the point of care that 175ml of fluid was taken at 10:37h on May 21, 2013 however the inspector observed resident #1494 was sleeping at this time. The thickened water was placed on the resident's bedside table and no assistance or monitoring of the resident was provided. The inspector observed that the level of water was unchanged at 11:30h. The licensee failed to ensure the care was provided to the resident as specified in the plan. [s. 6. (7)]

8. The inspector reviewed the health care record for resident #1493 on May 23, 2013. It is documented in the resident's plan of care that staff are to provide frequent 1-1 visits 1-2xs a week for social interaction. The flow sheets for the provision of activities, identified that the resident attended one activity in the past two months, further, 1:1 visits were not observed or documented as being provided in May 2013. The licensee failed to ensure that the care was provided to the resident as specified in the plan. [s. 6. (7)]

9. Resident #1494 has had a history of falls. Her plan of care identified as a fall prevention strategy to ensure a tabs monitor is attached to resident garments and is attached to call bell system. On May 23, 2013, the inspector observed that the tabs monitor was on the resident's bed and not attached to the resident's garments from 08:30h to 15:30hr. The tabs monitor was observed attached to the wheelchair and clothing at 16:30h. The licensee failed to ensure that the care was provided to the

resident as specified in the plan. [s. 6. (7)]

10. Inspector reviewed the health care records for resident #1523 and noted the plan of care identified the resident was to be offered the sensory room activity 1-2 times per week. Inspector reviewed the residents activation participation flow sheets for the last 3 months and noted that there is no documentation to support that the resident had received the sensory room activity. In an interview, the Life Enrichment Aide assigned to the unit confirmed that the resident had not been to the sensory room for a very long time. In addition, the plan of care directs that the resident is to participate in 2 activities per week. Review of the resident's activation participation records shows that in March 2013, resident received a total of 4 activities with no activities documented between March 1, 2013 and March 21, 2013. In reference to the April 2013 record, resident received a total of 6 activities. The licensee failed to ensure that the care was provided to the resident as specified in the plan. [s. 6. (7)]

11. Inspector observed that resident #1493 has a contraction. The physiotherapist assessed resident #1493 and identified specific interventions. Resident #1493 plan of care does identify these interventions, however, they were not observed to be implemented by inspector 151 or 158 during this inspection. The licensee failed to ensure the care was provided to the resident as specified in the plan. [s. 6. (7)]

12. The inspector reviewed resident #1494 health care record, including assessments, progress notes and plan of care. The progress notes identified that the resident was self transferring. The resident sustained an injury while self transferring. The plan of care does identify the resident's risk for falls as it relates to unsteady gait, however, it does not identify the resident's risky behaviour of self transferring. On May 17, 2013, an assessment using the Morse Fall Scale was completed by staff #S101 who identified that the resident #1494 was now a moderate risk to fall, which was a change from the high risk to fall previously assessed in November 2012 by staff #S102. Staff #S101 also identified in the May 2013 Morse Fall Scale that the resident had not fallen within the last 6 months, however, progress notes identify that the resident has fallen in the last six months as a result of self transferring. Resident #1494 was not reassessed or the plan of care reviewed when the resident's care needs changed. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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:

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. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Inspector observed care carts routinely stored in the entrance vestibule of the following resident rooms.
- May 13, 2013 room 206
- May 16, 2013 room 206 and 215.

The licensee failed to ensure the resident's right to be treated with courtesy and respect was fully promoted and respected. [s. 3. (1) 1.]

2. Inspector did daily walk through of the home and noted that staff were storing care carts and resident lifts in the vestibule of residents' rooms. On May 17 and 21, 2013, inspector observed that resident #1523 had both a care cart and a total lift stored in the vestibule of the resident's room. During a family interview on May 15, 2013, the resident's SDM stated that this was a routine practice by staff and that the family objected on the infringement of her mother's space. Inspector interviewed staff #S103 who stated that it was staff's routine practice to store the equipment in resident rooms because keeping them in the hallway presented a tripping hazard for residents. Staff #S103 stated that they did have a dedicated storage room on each unit for equipment storage but she was unsure as to why the room was not being used. The licensee failed to ensure the resident's right to be treated with courtesy and respect was fully promoted and respected. [s. 3. (1) 1.]

3. On May 22, 2013, inspector toured the home and noted the following:
- Rooms W110 , E109, E103, and W206 had care carts stored in the resident's room
- Rooms W215 and W212 had resident mechanical lifts stored in the resident's room.

The licensee failed to ensure the resident's right to be treated with courtesy and respect was fully promoted and respected. [s. 3. (1) 1.]

4. Inspector reviewed resident's #1516's health care record and noted that the resident had the ability to direct care and was having significant pain issues. Inspector noted a progress note that documented Staff #S1303 removed the resident's footwear as the PSW did not deem them appropriate footwear at the time. Resident asked another PSW to return the footwear and the request was complied with. Staff #S1303 returned to the resident to find the resident wearing the footwear and Staff #S1303 removed these from the resident and from the resident's room. The note identifies how upset the resident was having had the footwear removed. The licensee failed to ensure the resident's right to be treated with courtesy and respect was fully promoted and respected. [s. 3. (1) 1.]

5. On May 17, 2013, inspector observed the medication round on the Vermillion unit and noted that resident #1300 required blood glucose testing before medication administration. Inspector observed that this was done in the dining room where residents were gathered for the breakfast meal. Inspector noted that two other residents were in close proximity to the resident had direct view of the treatment. The licensee failed to ensure the resident's right to be afforded privacy in treatment was fully respected and promoted. [s. 3. (1) 8.]

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 right of all residents to be treated with respect and dignity, specifically, that resident care equipment is not stored in residents' rooms and/or room vestibules; resident's #1516 individuality is recognized and residents are provided privacy in treatment, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. On May 22, 2013, the inspector observed that staff #S104 on Vermillion added 1/2 scoop of the thickener to resident #1549's cup which contained 1/4 of fluid inside. The resident requested that water be added to which the staff member responded by adding more thickener. Inspector reviewed the thickening guideline which identifies the amount of thickener to be added to a certain volume of fluid for nectar thickened and honey thickened consistencies. Inspector noted the home has a variety of sizes of cups (double handles mugs, thermal cups) and that staff were not provided with direction of how much thickener to add, thus resulting in staff approximating how much thickener to add. The licensee failed to ensure that resident's are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. [s. 11. (2)]

2. Inspector observed the morning nutritional pass on May 21, 2013 noting two resident #1494 and #1756 have physician's orders to receive nectar thickened fluids. Inspector noted the nutritional list used by staff for this pass was not updated and did not contain any information related to newly admitted resident #1808. Inspector spoke with the two staff members completing the nutritional pass related to the use of thickener and thickened fluids. Staff #S110 identified to the inspector that 1 scoop of thickener is added to water and if the fluid is sweet (juice) then more thickener is required. The direction on the can of thickener, as read by the inspector, did not support this statement as it identifies that for 125mls of fluid requires 1 scoop of thickener to achieve a honey-like consistency and 1 ½ scoops of thickener to achieve a nectar-like consistency. The second staff #S111 reported to the inspector that she had not received any education related to thickened fluids. Inspector later spoke with the Food Service Supervisor who identified that an in-service related to thickened fluids was provided to staff approximately a year ago, however no documented record of this in-service was available for the inspector to review. Further, upon review of the home's policy, inspector noted the policy described the various textures of fluids however failed to provide direction on how to achieve these various textures using thickener. The licensee failed to ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. [s. 11. (2)]

3. Inspector noted that resident #1474 was provided thickened fluids during the morning nourishment pass on May 14,15 and 19, 2013. Inspector had observed the glass of fluid on the residents bedside table and noted that the resident did not consume any of the provided thickened fluid. Inspector spoke with the resident who reported that the staff leave the drink on the bedside table and it becomes so thick the resident is unable to drink it. The licensee failed to ensure that residents are provided

with food and fluids that are safe, adequate in quantity, nutritious and varied. [s. 11. (2)]

4. While observing the morning nutritional pass on May 21, 2013, inspector noted that thickened fluids were left at the bedside for resident #1494 and resident #1756. Inspector noted documentation completed at 10:37h for these two residents reflected that they received each 175mls of fluid. Upon a follow-up observation of these residents at 11:30h inspector noted the glasses of thickened fluids provided during the morning nutritional pass remained at the residents' bedsides unconsumed. The licensee failed to ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. [s. 11. (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 resident #1494, #1756 and #1549 are provided with fluids that are safe, adequate in quantity, nutritious and varied, 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:

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; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(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 :

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1. Inspector did a daily walk through and noted a recurrent issue. In the residents' washrooms, oral care equipment such as toothbrushes, toothpaste and toothettes are stored in a designated drawer of the vanity. On May 13, 14 and 15, 2013, inspector noted the following:
- Resident #1513's oral care equipment stored in this drawer was found as follows: toothbrush without cover, sitting directly on the bottom of the drawer where there was accumulated debris and dust. In addition, nail clippers were also found in the drawer and when drawer was opened, these rolled onto the toothbrush.
- Resident #1514's oral care equipment stored in this drawer was found as follows: toothbrush without cover, sitting directly on the bottom of the drawer where there was accumulated debris and dust. In addition, nail care equipment was also found in this drawer
- Resident #1549's oral care equipment stored in unsanitary manner - drawer dirty with accumulated debris and dust

The licensee failed to ensure that the home, furnishings and equipment is kept clean and sanitary. [s. 15. (2) (a)]

2. On May 13, 2013, inspectors toured the home and observed that several resident bedrooms and washrooms showed significant wall damage. Specifically, room WW201 in the washroom under towel bar, room WW201 contained wall damage behind rocker-recliner and room HF232 contained wall damage on wall facing the bed. Further, inspector noted the following areas showing varying degrees of wall damages:
- White Water Unit: doorways of lounge, dining room, in room 227, 214
- High Falls : rooms 214, 227 and 207.

Inspector interviewed the Environmental Service Manager who confirmed that prior to the inspection, there was no preventative maintenance program or quality assurance auditing process that would have alerted his department of the wall damage issues. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (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 residents' oral care equipment is stored in a manner that is clean and sanitary, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The inspector conducted a tour of the home on May 13, 2013 from 10:10h until 10:45h. During this tour, the inspector observed the following residents with call bells that were not easily accessible.
- Resident #1726 was observed sitting in a chair in room 228 and the call bell was located behind the head board, clipped to itself and not easily accessible to the resident.
- Resident #1717 was sitting in a chair in room 223 and the call bell was situated on far side of bed and not easily accessible to the resident.
- Resident #1707 who was sleeping in a chair in room 217 did not have access to the call bell as the call bell was located on far side of the resident's bed and not within reach.
- Resident #1718 was observed by the inspector sleeping in a chair in room 118 and did not have easy access to the call bell. The call bell was located on right far side of resident's bed and not within resident's reach.
The home did not ensure that four residents' call bells were easily accessible and used by residents, staff and visitors. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is easily seen, accessed and used by residents, staff and visitors at all times. [s. 17. (1) (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 the resident-staff communication and response system is easily seen, accessed and used by residents #1707, #1717, #1718, #1726 and all residents, staff and visitors at all times, to be implemented voluntarily.

WN #6: 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:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

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; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. Inspector reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect", last revision date of April 24, 2013. The policy statement identifies that "any employee who witnesses or becomes aware of or suspects resident abuse shall report it immediately to the Registered Staff/Director of Care/Administrator who will conduct a thorough and confidential investigation. On page 5 of the policy, under section identified as "Section Two: Reporting and Notifications about Incidents of Abuse or Neglect, there is a notation in reference to LTCHA 2007, S.O. 2007, c.8, s. 24 (1). This policy reference states : " Section 24 (1) of the LTCHA requires certain persons, including the facility and certain staff members, to make immediate reports to the Director". This reference contravenes the actual language of the referenced section of the act that directs that any person (as opposed to "certain staff") who has reasonable ground to suspect incidence of abuse or neglect is to immediately report the suspicion and the information upon which it is based to the Director". Although the home's Abuse Policy contains an explanation of the duty under section 24 to make mandatory reports, the information in the policy is not correct. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty under section 24 to make mandatory reports. [s. 20. (1)]

2. Staff #S105 documented in resident #1493 progress notes on that the resident reported staff actions which made the resident embarrassed and upset. This staff member informed the resident that the concerns would be passed along to the day nurse to follow up and that the incident would be identified on the 24 hour unit report. The progress notes did not contain any information regarding a follow up to this incident or that the resident's substitute decision-maker(SDM) was notified within 12 hours. The home's policy "Zero Tolerance of Abuse and Neglect" identifies that threatening, insulting, intimidating and humiliating gestures, behaviour and remarks are considered as emotional abuse. The policy identifies that staff are to report any witnessed, suspected or alleged abuse to a supervisor. The supervisor notifies the DOC/delegate immediately and initiates an investigation. The SDM is notified within 12 hrs of becoming aware of the incident. The home's policy on zero tolerance of abuse and neglect was not complied with by not reporting the incident to the DOC/delegate immediately, not initiating an investigation and not notifying the resident's substitute decision-maker. The licensee failed to ensure that the policy is complied with. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that the written policy to promote zero tolerance of abuse meets all requirements, specifically the explanation of the duty under section 24 for " any person who has reasonable grounds to suspect abuse of a resident to immediately report the suspicion", to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
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. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
9. Disease diagnosis. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

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1. Inspector reviewed resident #1516's health care records and interviewed staff in regards to responsive behaviours demonstrated by the resident. Inspector noted the resident displayed responsive behaviours. Inspector reviewed the resident's most recent plan of care and could find no focus or related strategies for the responsive behaviours. The licensee failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's mood and behaviour patterns. [s. 26. (3) 5.]

2. Inspector reviewed the health care record including plan of care for resident #1510. Inspector noted this resident was admitted to hospital, inspector reviewed the resident's plan of care related to the resident's new diagnosis and noted this diagnosis was not included. Inspector spoke with staff #S106 on May 17, 2013. Staff #S106 confirmed that the diagnosis was missing from the residents plan of care and proceeded to update it within point click care. The licensee failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's disease diagnosis. [s. 26. (3) 9.]

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 residents are based on an interdisciplinary assessment of the resident that includes the resident's disease diagnosis and responsive behaviours including potential triggers, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. Inspector spoke with the scheduling staff and the Director of Nursing and Personal Care. It was confirmed to the inspector that the home does not have a written staffing plan for the nursing and personal support services program. A template of schedules (master rotation) was available for review; however, no written staffing plan exists. The licensee failed to ensure a written staffing plan for the nursing and personal support services program was developed. [s. 31. (2)]

2. Inspector spoke with the Director of Nursing and Personal Care. It was identified to the inspector that the staffing plan is not based on an assessment of the residents' assessed safety and care needs and that the staffing plan is not evaluated and updated annually. The Director of Nursing and Personal Care did identify that MDS RAI data and information from plans of care are used to determine staffing, however no formal assessment or evaluation of the staffing plan has taken place. The licensee failed to ensure that the staffing plan is based on the residents' assessed care and safety needs and is evaluated and updated annually in accordance with evidence based practice, and if there are none, in accordance with prevailing practice. [s. 31. (3)]

3. Inspector reviewed the home's back-up staffing plan for nursing and personal care. Inspector noted this plan does not align with allowable exceptions under the regulations for at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff being on duty and present in the home at all times. The back-up staffing plan identifies that in the event a registered nurse cannot be replaced, a registered practical nurse is to assume the role of RPN supervisor. This exception is only available to homes with fewer than 64 licensed beds (this home is licensed for 128 beds). Inspector did review an updated copy of the home's back-up staffing plan after bringing the non-compliance forward to the site Administrator which aligned with the current exceptions. The licensee failed to ensure that the staffing plan includes a back-up plan that addresses situations when staff cannot come to work, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work. [s. 31. (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 a written staffing plan for the nursing and personal support services program is developed, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

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. O. Reg. 79/10, s. 48 (1).
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. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The home's "Pain Management Program identifies that a formal pain assessment is completed at admission and as required. The inspector reviewed resident #1494's health care records, including assessments and progress notes on May 22, 2013. Although there was a pain assessment was completed when the resident was admitted in 2011, the inspector did not find that a current pain assessment using a specific tool was completed. The MDS assessment completed in March 2013 identified that the resident has pain but failed to identify whether the interventions used to manage the resident's pain were effective. The licensee failed to ensure that the pain management program developed and implemented in the home identifies and manages pain in residents. [s. 48. (1) 4.]

2. The home's "Pain Management Program identifies that a formal assessment is completed at admission and as required. The physician re-ordered a narcotic to manage resident #1493 ongoing pain. The inspector reviewed resident #1493 health care records, including assessments and progress notes on May 22, 2013. Although a pain assessment using a specific tool was completed when the resident was admitted in 2011, the inspector did not find that a current pain assessment using a specific tool. The MDS assessment completed in February 2013 identified that the resident has pain but failed to identify whether the interventions used to manage the resident's pain were effective. The licensee failed to ensure that the pain management program developed and implemented in the home identifies and manages pain in residents. [s. 48. (1) 4.]

3. Inspector reviewed the home's pain management policy and noted a pain assessment should be completed on admission and when required. Inspector reviewed the health care record for resident #1549 and noted a pain assessment has not been completed since admission. Inspector spoke with the resident and staff #S107 who both identified ongoing pain concerns managed by pharmacologic interventions and the application of topical creams. Staff #S107 further confirmed that although pain assessment tools are available they have not been used to assess the management of resident #1549's pain. The licensee failed to ensure that the pain management program developed and implemented in the home identifies and manages pain in residents. [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 ensuring the pain management program in the home is fully implemented and identifies and manages pain in residents, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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 saillants :

1. The inspector observed the supper meal on May 22, 2013. It was noted that the noodles which was planned and posted as a menu item was not available or offered to resident #1494. The noodles were made available to the residents at 17:20h, however, it was at the end of the meal service when residents were finished eating their meal. The licensee failed to ensure that the planned menu items are offered and available at each meal and snack. [s. 71. (4)]

2. The inspector observed the supper meal on May 22, 2013. The meal service started in all home areas at 17:00h and was completed between 17:20h-17:25h on each unit. The planned menu was pot roast beef/mashed potatoes, carrots, mandarin oranges, or curried lamb with noodles and yam and caramel cheese cake. Inspector noted there were no noodles at the start of meal service in any of the home areas. The dietary aide identified mashed potatoes would be used as a substitution. The noodles became available at 17:20h however; the meal service was essentially completed by this time. The licensee failed to ensure that the planned menu items are offered and available at each meal and snack. [s. 71. (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 ensuring the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 82. Attending physician or RN (EC)

Specifically failed to comply with the following:

s. 82. (1) Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,
(a) conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination; O. Reg. 79/10, s. 82 (1).
(b) attends regularly at the home to provide services, including assessments; and O. Reg. 79/10, s. 82 (1).
(c) participates in the provision of after-hours coverage and on-call coverage. O. Reg. 79/10, s. 82 (1).

Findings/Faits saillants :

1. Inspector reviewed the health care record for resident #1510. Inspector noted the only documented physical examination of the resident by the physician was completed upon admission in 2011, no further annual physical examination was located. Inspector spoke with staff #S106 who confirmed no further physical examination by the physician had been completed. The licensee failed to ensure that either a physician or a registered nurse in the extended class conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination. [s. 82. (1) (a)]

2. Inspector reviewed the health care record for resident #1505. Inspector noted the only documented physical examination of the resident by the physician was completed upon admission in 2011, no further annual physical examination was located. Inspector spoke with staff #S106 who confirmed no further physical examination by the physician had been completed. The licensee failed to ensure that either a physician or a registered nurse in the extended class conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination. [s. 82. (1) (a)]

3. Inspector reviewed the health care record for resident #1494. Inspector noted the only documented physical examination of the resident by the physician was completed upon admission in 2011. No documented reports of physical examinations conducted in 2012 or 2013 were located. The licensee failed to ensure that either a physician or a registered nurse in the extended class conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination. [s. 82. (1) (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 resident #1494, #1505, #1510 and all residents of the home, receive an annual physical examination by a physician or a registered nurse in the extended class, and produces a written report of the findings, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector was notified that the bathtub on the Whitewater home area has been in disrepair and has not functioned since April 16, 2013. Resident #1499 stated in interviews on May 14 and 17, 2013 that the staff did not ask whether the resident would like a bath, which was the resident's preference, but rather, provided a shower instead. The inspector observed that the resident was given a shower without offering a bath on May 17 and 21, 2013. Staff #S108 stated that the resident is given a shower as the tub is broken on the unit. Resident #1499's plan of care identifies that the resident prefers a bath. The licensee failed to ensure the resident is bathed, at a minimum, twice a week by the method of his or her choice. [s. 33. (1)]

2. Inspector was notified that the bathtub on the Whitewater home area has been in disrepair and has not functioned since April 16, 2013. Resident #1494 stated in interviews on May 14, 17 and 21, 2013 that the staff did not ask whether the resident would like a bath, which is the resident's preference, but rather, provided a shower. The inspector observed that the resident was given a shower without asking the resident's preference on May 17 and 21, 2013. Staff #S108 and staff #S109 stated that the resident is given a shower as the tub is broken on the unit. Resident #1494's plan of care identifies that the resident prefers a bath which is given. The licensee failed to ensure the resident is bathed, at a minimum, twice a week by the method of his or her choice. [s. 33. (1)]

3. On May 14, 2013, inspector interviewed the resident #1516. Resident informed the inspector that staff have been forcing the resident to take a shower because the tub on the unit was broken. Resident stated that this was not acceptable and objected to being showered. Inspector reviewed the resident plan of care and noted that resident is identified to require a "whirlpool tub bath". In an interview, Staff #S1301 confirmed that the resident resisted showers every time and that it took "some convincing and reminders that the tub was broken" to get the resident's cooperation to shower. Staff #S1301 stated that at no time, was the resident offered to have a tub bath on any other unit as the staff member did not know that this was an option. The licensee failed to ensure that the resident is bathed, at a minimum, twice a week by the method of his or her choice. [s. 33. (1)]

4. In an interview, staff #S1302 confirmed that the tub on the whitewater home area had been broken for over one month. Staff #S1302 stated that if residents are adamant having an actual tub bath, it could be scheduled on another unit, but would not likely happen on the resident's bath day as the added bath would have to be

arranged around that unit's bathing schedule. The licensee failed to ensure that the resident is bathed, at a minimum, twice a week by the method of his or her choice. [s. 33. (1)]

WN #13: 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:

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. Inspector observed on May 13, 14, 15, 16 and 17, 2013, that resident #1499's nails were long with dirt build up. The resident's plan of care identifies staff to ensure the resident's hair is washed and nails are manicured on bath days. The licensee failed to ensure the resident receives fingernail care, including the cutting of fingernails. [s. 35. (2)]

2. Inspector observed on May 13, 14, 16, 17, and 21, 2013, that resident #1494 finger nails were long, jagged with dirt build up. The inspector observed that resident #1494 received a shower on May 17, and on May 21, 2013; however the resident's nails were not trimmed/manicured. On May 22, 2013, the inspector observed the resident to constantly touch the resident's nails and when asked if the nails bothered the resident, the resident stated "yes, but the girls did not have time to trim them". The resident's plan of care identifies the resident's nails be manicured on bathing day. The licensee failed to ensure the resident receives fingernail care, including the cutting of fingernails. [s. 35. (2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. Inspector noted the resident's plan of care identified resident #1505's preference to go to bed at 19:00h. Inspector interviewed the resident's substitute decision-maker who identified that the resident is often put to bed around 18:00h and this is too early and makes it difficult for visiting in the evenings. Inspector observed on May 21, 2013 that the resident was transferred to bed by two PCAs at 18:20h. Inspector noted both PCAs had completed evening care for resident #1505 and the resident was alone in the room in bed at 18:30h. The licensee failed to ensure the residents desired bedtime and rest routine is supported to promote comfort, rest and sleep. [s. 41.]

2. During a tour of the home on May 22, 2013 between 17:45h and 18:00h inspector observed residents #1551, #1646, #1546, #1710, #1716 and #1722 in bed having already received bedtime care. Inspector reviewed the plans of care for these residents and noted each resident had a preferred bed time between 19:00h and 22:00h (one at 19:00h, four at 20:00h and one at 22:00h). The licensee failed to ensure the residents desired bedtime and rest routine was supported to promote comfort, rest and sleep. [s. 41.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. On May 14, 2013, during an interview with the inspector 151, resident # 1493 identified that the food tastes the same and is bland. On May 22, 2013, resident #1755, resident #1705, and resident #1499 complained that the beef served at supper was tough and difficult to chew and that the vegetables (carrot and yams) were cold. Inspector tasted the regular textured menu items served to the residents on May 22, 2013 and found that the beef was difficult to chew, the carrots were cold and the yams were cold and had a course texture. The inspector tasted the puree meat which was bland tasting. The licensee failed to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, preserve taste, nutritive value appearance and food quality. [s. 72. (3) (a)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. In an interview, the Chairperson for the Family Council, confirmed that the home had recently sent a satisfaction questionnaire to residents and families. The chairperson states that she had no recollection of any discussion at any meeting in regards to a request by the home for the input into the development of the planned 2013 questionnaire. Inspector reviewed the minutes of the last 3 meetings and did not find any reference to the satisfaction questionnaire. Inspector interviewed the Site Administrator who confirmed that, though the Family Council was apprised that the home would be sending out the questionnaire on March 18, 2013, the home did not seek the council's input as to any revision or addition of the existing survey. The licensee failed to seek the advice of the Family Council, if any, in developing and carrying out the survey. [s. 85. (3)]

2. Inspector interviewed the Chairperson for the Resident's Council and the designated Staff Facilitator. The Chairperson could not recall with certainty if the Council had been approached in regards to the development of the satisfaction survey. In an interview, the Staff Facilitator stated that home had carried out a resident/family satisfaction questionnaire approximately one month ago. The Facilitator stated that she attended all of the meetings and to the best of her recollection, the Council did not have an opportunity to provide advice regarding the development of the 2013 satisfaction survey. Inspector reviewed the minutes of the last three Resident Council meetings and did not find any reference to the satisfaction surveys. Inspector interviewed the Site Administrator who confirmed that for the latest 2013 satisfaction questionnaire, the councils were not asked for input in the development of the satisfaction. The licensee failed to seek the advice of the Resident Council in developing and carrying out the survey. [s. 85. (3)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. It was noted by Inspector 158, during stage one of the inspection, that resident #1502 had medication at the bedside. Inspector 151 toured the unit on May 17, 21, 22 and 23 and found that on each of these tours, resident #1502 had medication at the bedside. Inspector 151 spoke with the resident and asked about the medication. Resident stated the medication is for self administration. Inspector reviewed resident #1502's health care records and noted that the order for the medication identifies the resident may not have at the bedside. The licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. [s. 131. (5)]

2. It was noted by Inspector 158, during stage one of the inspection, that resident #1502 had medication at the bedside. Inspector 151 toured the unit on May 17, 21, 22 and 23 and found that on each of these tours, resident #1502 had medication at the bedside. Inspector 151 spoke with the resident and asked about the medication. Resident stated the medication is for self administration. Inspector reviewed resident #1502's health care records and noted that the order for the medication identifies the resident may not have at the bedside. The licensee failed to ensure that no resident who is permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident. [s. 131. (7)]

WN #18: 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. On March 27, 2013, the physician ordered a narcotic for resident #1494 who has pain. Inspector reviewed this resident's health care records including the progress notes and assessments. The inspector was unable to locate documentation of the resident's response and the effectiveness of the newly prescribed narcotic. Resident #1494's response and the effectiveness of the narcotic was not documented. The licensee failed to ensure that monitoring and documentation of the resident's response and the effectiveness of the drug appropriate to the risk level of the drug was completed. [s. 134. (a)]

2. On May 14, 2013, the physician re-ordered a narcotic for resident #1493 as an intervention for pain control. Inspector reviewed the resident's health care records including the progress notes and assessments. The inspector was unable to locate documentation of the resident's response and the effectiveness of the narcotic. The response and the effectiveness of the narcotic was not documented for resident #1493. The licensee failed to ensure that monitoring and documentation of the resident's response and the effectiveness of the drug appropriate to the risk level of the drug was completed. [s. 134. (a)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
1. The resident's ability under subsection 82 (2) of this Regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1). O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. The inspector reviewed the home's admission package on May 17, 2013. Although, the package included information on the ability to retain a physician, it fails to include the ability to retain a RN (EC) to perform the required services. The licensee failed to ensure the package of information for residents includes the ability to retain a RN (EC) to perform the required services. [s. 224. (1) 1.]

Issued on this 19th day of June, 2013

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