Ministry of Health and Long-Term Care

Ministère 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

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

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MONIQUE BERGER (151) - (A2)
Inspection No. / No de l'inspection :	2013_138151_0008 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / Registre no. :	S-000001-13 (A2)
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 31, 2013;(A2)
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE YORK 333 YORK STREET, SUDBURY, ON, P3E-5J3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : SANDRA MOROSO

To EXTENDICARE (CANADA) INC., 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. 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 :

(A2)
The licensee shall develop, submit and implement a plan that will ensure 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.

This plan must be submitted in writing to Inspector Monique Berger at 159 Cedar Street, Suite 603, Sudbury, ON P3E 6A5 or by fax at 1-705-564-3133 on or before May 15, 2013. Full compliance with this order shall be by Sept. 30, 2013

Grounds / Motifs :

1. Inspector #196 reviewed the current plan of care (POC) for resident #645 and noted conflicting information regarding the resident's ambulation ability:
- Under the focus of "ADL-TRANSFER, the plan of care identified that the resident required extensive assistance in and out of bed. For transfers, the resident required a mechanical lift with 2 staff. The POC further identified that the resident was wheelchair dependent for mobility and that the resident was independent in the use of the wheelchair for locomotion.
- Under the focus FALLS, the POC identified that the resident was prone to falls related to a shuffling gait. In the related interventions, staff were directed to "monitor (resident) closely when up walking with walker, has shuffling gait due to ulcers on his heels".
It is unclear if the resident is ambulating with the use of the walker or is dependent on a wheelchair for ambulation
. The care plan does not provide clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)] (196)

(196)

2. Inspector 196 reviewed the current care plan for resident #645 and noted that though the resident is identified as continent for bowel, the plan of care does not indicate the method to achieve this
The care plan did not provide clear directions to staff to guide the provision of bowel care for the resident. [s. 6. (1) (c)] (196)

(196)

3. Inspector 158 reviewed resident #838's assessment and noted the resident exhibited the behaviour of resisting care but that this behaviour was easily re-directed by staff. On 5 days of the 10 day inspection, the Inspector observed the resident inappropriately dressed for the time of day.
Inspector noted in the resident's plan of care that the resident was independent in dressing self but that the resident required much encouragement to do so. There were no specific strategies identified in the plan of care to direct staff as to how to encourage the resident to dress appropriately for the time of day. Further, the issue of refusing or resisting care is not addressed in the plan of care. . The plan of care did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)] (158
(158)

4. Inspector 151 reviewed resident #782's health care records and noted that the resident has had 8 falls in the last 6 months.. Inspector reviewed the post-fall assessments and noted that the home had identified several causes for the falls. The Inspector observed the resident and noted the resident had a chair/ bed alarm attached to the resident's shirt. None of these factors or bed alarm strategy was reflected in the resident's falls management plan of care.
The plan of care does not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)] (151)

(151)

5. Inspector reviewed progress notes for resident #838 and noted that the record stated the resident's was having unusual difficulties with continence care.
Inspector reviewed the resident's plan of care and noted that it did not address the unusual continence care issues.
The plan of care does not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)] (158)

(158)

6. Inspector 158 noted that on February 25, March 1 and March 4, 2013, the floor beside resident #838's bed was wet, sticky and smelling of urine. Subsequently, the Inspector reviewed the resident's health care record, including the urinary continence assessments, flow sheets, progress notes and the plan of care. In an interview regarding the resident's continence care, Staff # 010 stated that the resident was occasionally incontinent of urine, refuses to wear a product, was not on a toileting schedule and peri care was provided to the resident by staff when incontinent.

Review of health care records shows conflicting assessments and observations. For example:
- December 2012 RAP (Resident Assessment Protocol) identified the resident at risk for incontinence related to occasional incontinence and that the resident did wear a product to try and manage incontinence.
- the continence assessment completed on December 2012 indicated that the resident was continent
- audit of flow sheets from September to November 2012 showed that the resident was experiencing increasing frequency of urinary incontinence,
- Progress notes identified that the resident had been "having a few accidents and was not getting to the washroom on time".
- In addition, another progress note identified that the resident had been voiding in inappropriate places.

Inspector 151 reviewed the resident's plan of care and noted that the plan of care with the focus CONTINENCE, advised staff the resident was usually continent of urine and the only intervention was to document voiding every shift. Under the focus of TOILETING, staff was directed to "ask the resident throughout the day to toilet, resident can be left unattended on toilet and the resident is independent with toileting with some supervision and cueing".

The plan of care is not an accurate representation of the resident's continence care needs and assessments. The plan of care does not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

(158)

7. Inspector 151 reviewed resident #0005's health record and most current plan of care. Inspector noted that the plan of care described the resident as follows: requiring limited assistance for toilet use, requiring a containment continence care product, independent with ambulation with the use of a walker and "can reach the toilet independently". In regards to mobility, the resident was described as independent with walking in hallway with walker and independent with bed mobility. For hygiene, the resident was requiring only cuing and guidance. In regards to communication, the resident was able to orally converse in both English and French

Inspector reviewed the resident's health care record and interviewed staff, both of these confirming the resident had a significant change in health status that affected the resident's ability to communicate, to ambulate and transfer, to do any activity of daily living without extensive staff assistance. In addition the resident was identified to have an infection and that the resident was palliative. None of these changes were reflected in the plan of care.

The plan of care does not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)] (151)

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(151)

8. Inspector reviewed resident #817's health care record and noted that the resident had several significant health care concerns. Inspector reviewed the resident's plan of care and noted several instances where direction to staff was not clear. These are as follows:

a.) Under 2 different foci of the plan, it is indicated that the resident is to be repositioned every 2 hours. Interview with staff and Assistant Director of Care (ADOC) confirmed that staff did not re-position the resident as the activity caused the resident too much discomfort. ADOC stated that the resident had a specialty mattress that was programmed to change the resident's body pressure points from left to right automatically. This negated the need to reposition the resident. ADOC confirmed that the care plan was unclear in regards to the need to re-position the resident.

b.)Under the focus of "TOILET": staff are apprised that the resident is to be toileted and is on an incontinent product containment program. Under a different focus, staff are directed not to toilet the resident. This information was reviewed with ADOC who confirmed that resident is not a candidate for a toileting program and that the POC does not have accurate information in relation to toileting.

c.)Review of the resident's health records shows that the resident has moderate to severe pain almost daily. Resident's plan of care in regards to pain management addresses only of the resident's sites of pain and only references pharmaceutical modalities.
The plan of care does not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

The plan of care does not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)] (151)

(151)

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

Sep 30, 2013(A2)

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2011_029134_0003, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

(A2)
The licensee will prepare, submit and implement a plan that will ensure that, for all residents, the care set out in the plan of care is based on assessment of the resident and the needs and preferences of the resident.

This plan must be submitted in writing to Inspector Monique Berger at 159 Cedar Street, Suite 603, Sudbury, ON P3E 6A5 or by fax at 705-564-3133 on or before May 15, 2013. Full compliance with this order shall be by Sept. 30, 2013

Grounds / Motifs :

1. Inspector 151 reviewed resident #0005's health record and most current plan of care. Inspector noted that the plan of care described the resident as follows: requiring limited assistance for toilet use, requiring a containment continence care product, independent with ambulation with the use of a walker and "can reach the toilet independently". In regards to mobility, the resident was described as independent with walking in hallway with walker and independent with bed mobility. For hygiene, the resident was requiring only cuing and guidance. In regards to communication, the resident was able to orally converse in both English and French

Inspector reviewed the resident's health care record and interviewed staff, both of these confirming the resident had a significant change in health status that affected the resident's ability to communicate, to ambulate and transfer, to do any activity of daily living without extensive staff assistance. In addition the resident was identified to have an infection and that the resident was palliative. None of these changes were reflected in the plan of care.

The plan of care was not based on the assessment of the resident and the needs and preferences of that resident. [s. 6. (2)] (151)

(151)

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

Sep 30, 2013(A2)

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

(A2)
The licensee shall develop, submit and implement a plan that will ensure for all residents 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

This plan must be submitted in writing to Inspector Monique Berger at 159 Cedar Street, Suite 603, Sudbury, ON P3E 6A5 or by fax at 1-705-564-3133 on or before May15, 2013. Full compliance with this order shall be by Sep.30, 2013

Grounds / Motifs :

1. Inspector 151 reviewed resident #0005's health record and most current plan of care. Inspector noted that the plan of care described the resident as follows: requiring limited assistance for toilet use, requiring a containment continence care product, independent with ambulation with the use of a walker and "can reach the toilet independently". In regards to mobility, the resident was described as independent with walking in hallway with walker and independent with bed mobility. For hygiene, the resident was requiring only cuing and guidance. In regards to communication, the resident was able to orally converse in both English and French

Inspector reviewed the resident's health care record and interviewed staff, both of these confirming the resident had a significant change in health status that affected the resident's ability to communicate, to ambulate and transfer, to do any activity of daily living without extensive staff assistance. In addition the resident was identified to have an infection and that the resident was palliative. None of these changes were reflected in the plan of care.

The plan of care differed significantly from staff accounts. Staff and others involved in the different aspects of care of the resident did not collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other. [s. 6. (4) (a)]
(151)
(151)

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

Sep 30, 2013(A2)

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

(A2)
The licensee develop, submit and implement a plan that will ensure that for every resident, the resident s substitute decision maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident s plan of care.

. This plan must be submitted in writing to Inspector Monique Berger at 159 Cedar Street, Suite 603, Sudbury, ON P3E 6A5 or by fax at 1-705-564-3133 on or before May 15, 2013. Full compliance with this order shall be by Sept. 30, 2013

Grounds / Motifs :

1. Inspector 158 interviewed resident #782's Substitute Decision Maker (SDM) who stated that the resident had ill fitting dentures. SDM stated that the family had brought in a fixative cream and had asked the staff to apply this to the resident's dentures. Inspector 151 observed the resident and confirmed that the resident had loose fitting dentures. Inspector reviewed the resident's plan of care and could find no reference to the family's request. The resident, the SDM, if any, and the designate of the resident/SDM been not been given an opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)] (151) (151)

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

Sep 30, 2013(A2)

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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 :

(A2)
The licensee shall develop, submit and implement a plan to ensure that for every resident, the care set out in the plan of care is provided to the resident.

This plan must be submitted in writing to Inspector Monique Berger at 159 Cedar Street, Suite 603, Sudbury, ON P3E 6A5 or by fax at 1-705-564-3133 on or before May 15, 2013. Full compliance with this order shall be by Sept.30, 2013

Grounds / Motifs :

1. Inspector 158 reviewed resident #784's health care records. This review included the resident's assessments, progress notes and the plan of care. Inspector noted that the Dietician assessed the resident as at risk for choking and as a result, changed the diet texture to puree, directed staff to serve the resident bread with no crust and to use an adaptive lipped border plate to serve the resident the meals. This information was also found in the nutritional plan of care and on the "Dining Room - Meal Reference sheet".

The Inspector observed the resident at a supper meal and noted that staff # 014 referenced the "Dining Room - Meal Reference Sheet" when calling out resident meals. When it came to call resident # 784's meal, the staff person called out the resident's preference for the entrée and stated that the resident was to have "diabetic regular texture". Staff #014 did not reference the need for crust-less bread or the need for a lipped/border plate. The resident received a regular texture diet, bread with crust and in a regular flat plate.

The home did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)] (158)

(158)

2. Inspector 196 observed resident #601 sitting in the dining room with hair dishevelled. Inspector reviewed the resident's plan of care and noted that staff was directed to remind the resident to comb their hair as part of the resident's hygiene and grooming procedure. In an interview, staff #018 confirmed that the resident did require reminders to "wash own face and hands, and comb hair and get dressed". On March 6, 2013, resident #601 was not provided with care as is specified in the plan of care. [s. 6. (7)] (196). (196)

3. . Inspector 158 observed the evening meal service and noted that resident # 017 picked at and played with the food presented throughout the meal service. The resident was observed to take several small bites but did not eat much of the meal. Inspector noted that no staff assistance or encouragement was given to the resident.

Inspector reviewed resident #017's health care records and noted in the plan of care the resident required extensive encouragement by staff to complete the meals and required staff assistance when the resident was not eating.

The home did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan [s. 6. (7)] (158)

(158)

4. . Inspector 158 observed that resident #041 used a fork to pick at food but did not eat the supper meal. No assistance or encouragement by staff was given to the resident during the meal service.
Inspector reviewed the resident's health care record and noted that the resident required extensive encouragement by staff to complete the meals and that assistance was to be provided when the resident was not eating independently.

The home did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)] (158)
(158)

5. . Inspector 158 reviewed resident # 838's health care records. In regards to the resident's recreational and social program, records identified that it was the resident's preference to not go to large group activities or religious events. The activation assessment for this resident identified the resident to enjoy playing board games, and that one-to-one sessions were to be provided. In addition, the resident was to be provided with daily reading materials.

Inspector reviewed the activation flow sheets for this resident from February 25 to March 8, 2013. Inspector noted there was no documentation of one-on-one activities. Inspector made multiple observations of this resident during the two-week Resident Quality Inspection. At no time, did the Inspector observe the resident engaged in one-on-one activity. In addition Inspector observed that in the resident's room, the reading material was layered in dust.

The care set out in the plan of care was not provided to the resident as specified in the plan [s. 6.(7)] (158)

(158)

6. Inspector 158 noted that Staff #015 had made changes to resident # 838's care plan. The changes made were in reference to the resident's toileting program. The direction to staff was to ensure that the resident was on an every 2 hour toileting plan. The intervention included that staff were to remind and assist the resident with toileting needs every 2 hours.

Inspector observed the resident from 0900 h to 1215 h: During this time period, the resident was at breakfast, returned to the room, received morning fluid pass and returned to the dinning room for lunch. At no time during this period of observation was any staff observed to remind the resident to toilet or did staff offer assistance to toilet.

The care set out in resident # 838's plan of care was not provided. [s. 6. (7)] (158)

(158)

7.
Inspector 158 made multiple observations that resident # 784's bottom denture slipped each time the resident spoke. Inspector reviewed the resident's plan of care. It was documented that the resident required total assist with use and care of dentures and the staff were to ensure the resident's dentures fit and were in the mouth correctly. The care that was set out in the resident's plan of care was not provided to the resident. [s. 6. (7)] (158)
(158)

8. On February 27,2013 at 0900 and 1100 h, Inspector observed that the call bell was on the floor behind the resident's head board. Inspector 158 reviewed resident # 838's health care record , including the care plan. Falls related to cognitive loss and physical limitation is identified in the resident's plan of care. One of the falls intervention is to ensure that the call bell is within reach of resident.
The care set out in the resident's plan of care was not provided. (158)

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

Sep 30, 2013(A2)

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

(A2)
The licensee shall develop, submit and implement a plan to ensure that every 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.

This plan must be submitted in writing to Inspector Monique Berger at 159 Cedar Street, Suite 603, Sudbury, ON P3E 6A5 or by fax at 1-705-564-3133 on or before May 15, 2013. Full compliance with this order shall be by Sept.30, 2013

Grounds / Motifs :

1. Inspector 151 reviewed resident #0005's health record and most current plan of care. Inspector noted that the plan of care described the resident as follows: requiring limited assistance for toilet use, requiring a containment continence care product, independent with ambulation with the use of a walker and "can reach the toilet independently". In regards to mobility, the resident was described as independent with walking in hallway with walker and independent with bed mobility. For hygiene, the resident was requiring only cuing and guidance. In regards to communication, the resident was able to orally converse in both English and French

Inspector reviewed the resident's health care record and interviewed staff, both of these confirming the resident had a significant change in health status that affected the resident's ability to communicate, to ambulate and transfer, to do any activity of daily living without extensive staff assistance. In addition the resident was identified to have an infection and that the resident was palliative. None of these changes were reflected in the plan of care.

When the resident experienced a significant change in her health status, it became apparent the resident's care needs had changed and the current plan of care was no longer appropriate. The resident was not reassessed and the plan of care was not reviewed and revised . (151)

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

Sep 30, 2013(A2)

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 31 day of May 2013 (A2)

Signature of Inspector / Signature de l'inspecteur : Monique G. Berger

Name of Inspector / Nom de l'inspecteur : MONIQUE BERGER - (A2)

Service Area Office / Bureau régional de services : Sudbury

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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection/ Genre d'inspection
May 31, 2013;	2013_138151_0008 (A2)	S-000001-13	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE YORK
333 YORK STREET, SUDBURY, ON, P3E-5J3

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

MONIQUE BERGER (151) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): February 25,26,27,28, March 1, 4,5,6,7,8, 2013

Resident Quality Inspection done

In tandem to this inspection: the issues concerning following critical incidents were inspected:

- S-000958-12 related to CI:2604-0000029-12

- S-001021-12 related to CI:2604-0000030-12

- S-001040-12 related to CI:2604-0000031-12

- S-000324-12 related to CI:2604-0000010-12

- S-000443-12 related to CI:2604-0000015-12

- S-000529-12 related to CI:2604-0000016-12

- S-000742-12 related to CI:2604-0000023-16

- S-000541-12 related to complaint

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care, Social Worker, Finance Manager, Manager for Activation and Life Enrichment, Manager for Maintenance, Manager for Housekeeping, Manager for Laundry, Food Service Supervisors, Dietician, Registered Staff, Personal Support Workers (PSWs), President of Family Council, President of Resident Council, Residents, Family members and visitors

During the course of the inspection, the inspector(s)

- made direct observations of the delivery of care and services to residents,

- did daily walk-through of the home,

- reviewed resident health care records,

- reviewed policies and procedures,

- reviewed the home's programs in regards to the management of responsive behaviours, falls management, pain management, continence care, skin and wound care, palliative care, dialysis

- reviewed the home's medication management systems,

- reviewed the home's activation program,

- reviewed the homes risk management and quality assurance program,

- reviewed the home's policies in regards to prevention of abuse and neglect,

- reviewed staffing plan, schedules and related policies and procedures,

- reviewed the home's accommodation services for laundry, housekeeping and maintenance and their related policies and procedures,

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Trust Accounts

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 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. (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 2007, c. 8, s. 6 (4).
(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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

s. 6. (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 resident #817's health care record and noted that the resident had several significant health care concerns. Inspector reviewed the resident's plan of care and noted several instances where direction to staff was not clear. These are as follows:

a.) Under 2 different foci of the plan, it is indicated that the resident is to be repositioned every 2 hours. Interview with staff and Assistant Director of Care (ADOC) confirms that staff do not re-position the resident as the activity causes the resident too much discomfort. ADOC states that the resident has a specialty mattress that is programmed to change the resident's body pressure points from left to right automatically. This negates the need to reposition the resident. ADOC confirms that the care plan is unclear in regards to the need to re-position the resident.

b.)Under the focus of "TOILET": staff are apprised that the resident is to be toileted and is on an incontinent product containment program. Under a different focus, staff are directed not to toilet the resident. This information was reviewed with ADOC who confirmed that resident is not a candidate for a toileting program and that the POC does not have accurate information in relation to toileting.

c.)Review of the resident's health records shows that the resident has moderate to severe pain almost daily. Resident's plan of care in regards to pain management addresses only the pain of wound sites and only references pharmaceutical modalities.
The plan of care does not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. Inspector 151 reviewed resident #0005's health record and most current plan of care. Inspector noted that the plan of care described the resident as follows: requiring limited assistance for toilet use, requiring a containment continence care product, independent with ambulation with the use of a walker and "can reach the toilet independently". In regards to mobility, the resident was described as independent with walking in hallway with walker and independent with bed mobility. For hygiene, the resident was requiring only cuing and guidance. In regards to communication, the resident was able to orally converse in both English and French

Inspector reviewed the resident's health care record and interviewed staff, both of these confirming the resident had a significant change in health status that affected the resident's ability to communicate, to ambulate and transfer, to do any activity of

daily living without extensive staff assistance. In addition the resident was identified to have an infection and that the resident was palliative. None of these changes were reflected in the plan of care.

The plan of care does not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. Inspector 158 noted that on February 25, March 1 and March 4, 2013, the floor beside resident #838's bed was wet, sticky and smelling of urine. Subsequently, the Inspector reviewed the resident's health care record, including the urinary continence assessments, flow sheets, progress notes and the plan of care.
In an interview regarding the resident's continence care, Staff # 010 stated that the resident was occasionally incontinent of urine, refuses to wear a product, was not on a toileting schedule and peri care was provided to the resident by staff when incontinent.

Review of health care records shows conflicting assessments and observations. For example:
- December 2012 RAP (Resident Assessment Protocol) identified the resident at risk for incontinence related to occasional incontinence and that the resident did wear a product to try and manage incontinence.
- the continence assessment completed on December 2012 indicated that the resident was continent
- audit of flow sheets from September to November 2012 showed that the resident was experiencing increasing frequency of urinary incontinence,
- Progress notes identified that the resident had been "having a few accidents and was not getting to the washroom on time".
- In addition, another progress note identified that the resident had been voiding in inappropriate places.

Inspector 151 reviewed the resident's plan of care and noted that the plan of care with the focus CONTINENCE, advised staff the resident was usually continent of urine and the only intervention was to document voiding every shift. Under the focus of TOILETING, staff were directed to "ask the resident throughout the day to toilet, resident can be left unattended on toilet and the resident is independent with toileting with some supervision and cueing".

The plan of care is not an accurate representation of the resident's continence care

needs and assessments. The plan of care does not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

4. Inspector reviewed a progress note for resident #838 and noted that the record stated the resident's was having unusual difficulties with continence care.
Inspector reviewed the resident's plan of care and noted that it did not address the unusual continence care issues.
The plan of care does not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

5. Inspector 151 reviewed resident #782's health care records and noted that the resident has had 8 falls between November 1, 2012 and March 7, 2013. Inspector reviewed the post-fall assessments and noted that the home had identified several causes for the falls. The Inspector observed the resident and noted the resident had a chair/ bed alarm attached to the resident's shirt. None of these factors or bed alarm strategy was reflected in the resident's falls management plan of care.
The plan of care does not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

6. Inspector 158 reviewed resident #838's assessment and noted the resident exhibited the behaviour of resisting care but that this behaviour was easily re-directed by staff. On 5 days of the 10 day inspection, the Inspector observed the resident inappropriately dressed for the time of day.
Inspector noted in the resident's plan of care that the resident was independent in dressing self but that the resident required much encouragement to do so. There were no specific strategies identified in the plan of care to direct staff as to how to encourage the resident to dress appropriately for the time of day. Further, the issue of refusing or resisting care is not addressed in the plan of care. The plan of care did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

7. Inspector 196 reviewed the current care plan for resident #645 and noted that though the resident is identified as continent for bowel, the plan of care does not indicate the method to achieve this.
The care plan did not provide clear directions to staff to guide the provision of bowel care for the resident. [s. 6. (1) (c)]

8. Inspector #196 reviewed the current plan of care (POC) for resident #645 and noted

conflicting information regarding the resident's ambulation ability:
- Under the focus of "ADL-TRANSFER , the plan of care identified that the resident required extensive assistance in and out of bed. For transfers, the resident required a mechanical lift with 2 staff. The POC further identified that the resident was wheelchair dependent for mobility and that the resident was independent in the use of the wheelchair for locomotion.
- Under the focus FALLS, the POC identified that the resident was prone to falls related to a shuffling gait. In the related interventions, staff were directed to "monitor (resident) closely when up walking with walker, has shuffling gait due to ulcers on his heels".

It is unclear if the resident is ambulating with the use of the walker or is dependent on a wheelchair for ambulation. The care plan does not provide clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

9. Inspector 151 reviewed resident #0005's health record and most current plan of care. Inspector noted that the plan of care described the resident as follows: requiring limited assistance for toilet use, requiring a containment continence care product, independent with ambulation with the use of a walker and "can reach the toilet independently". In regards to mobility, the resident was described as independent with walking in hallway with walker and independent with bed mobility. For hygiene, the resident was requiring only cuing and guidance. In regards to communication, the resident was able to orally converse in both English and French

Inspector reviewed the resident's health care record and interviewed staff, both of these confirming the resident had a significant change in health status that affected the resident's ability to communicate, to ambulate and transfer, to do any activity of daily living without extensive staff assistance. In addition the resident was identified to have an infection and that the resident was palliative. None of these changes were reflected in the plan of care.

The plan of care was not based on the assessment of the resident and the needs and preferences of that resident. [s. 6. (2)]

10. Inspector 151 reviewed resident #0005's health record and most current plan of care. Inspector noted that the plan of care described the resident as follows: requiring limited assistance for toilet use, requiring a containment continence care product, independent with ambulation with the use of a walker and "can reach the toilet independently". In regards to mobility, the resident was described as independent with

walking in hallway with walker and independent with bed mobility. For hygiene, the resident was requiring only cuing and guidance. In regards to communication, the resident was able to orally converse in both English and French

Inspector reviewed the resident's health care record and interviewed staff, both of these confirming the resident had a significant change in health status that affected the resident's ability to communicate, to ambulate and transfer, to do any activity of daily living without extensive staff assistance. In addition the resident was identified to have an infection and that the resident was palliative. None of these changes were reflected in the plan of care.

The plan of care differed significantly from staff accounts. Staff and others involved in the different aspects of care of the resident did not collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other. [s. 6. (4) (a)]

11. Inspector 158 interviewed resident #782's Substitute Decision Maker (SDM) who stated that the resident had ill fitting dentures. SDM stated that the family had brought in a fixative cream and had asked the staff to apply this to the resident's dentures. Inspector 151 observed the resident and confirmed that the resident had loose fitting dentures. Inspector reviewed the resident's plan of care and could find no reference to the family's request. The resident, the SDM, if any, and the designate of the resident/SDM been not been given an opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

12. Inspector 158 reviewed resident # 838's health care record. In the plan of care, under the focus:FALLS, it was identified that the resident was at risk for falls. One of the interventions was to ensure that the call bell was within reach of resident.
On two separate occasion the Inspector observed that the call bell was on the floor behind the resident's head board.
The care that was set out in the resident's plan of care was not provided to resident. [s. 6. (7)]

13. Inspector 158 reviewed resident #784's health care records. This review included the resident's assessments, progress notes and the plan of care. Inspector noted that the Dietician assessed the resident as at risk for choking and as a result, changed the diet texture to puree, directed staff to serve the resident bread with no crust and to use

an adaptive lipped border plate to serve the resident the meals. This information was also found in the nutritional plan of care and on the "Dining Room - Meal Reference sheet".

The Inspector observed the resident at a supper meal and noted that staff # 014 referenced the "Dining Room - Meal Reference Sheet" when calling out resident meals. When it came to call resident # 784's meal, the staff person called out the resident's preference for the entrée and stated that the resident was to have "diabetic regular texture". Staff #014 did not reference the need for crust-less bread or the need for a lipped/border plate. The resident received a regular texture diet, bread with crust and in a regular flat plate.
The home did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

14. Inspector 158 made multiple observations that resident # 784's bottom denture slipped each time the resident spoke. Inspector reviewed the resident's plan of care. It was documented that the resident required total assist with use and care of dentures and the staff were to ensure the resident's dentures fit and were in the mouth correctly. The care that was set out in the resident's plan of care was not provided to the resident. [s. 6. (7)]

15. Inspector 158 noted that Staff #015 had made changes to resident # 838's care plan. The changes made were in reference to the resident's toileting program. The direction to staff was to ensure that the resident was on an every 2 hour toileting plan. The intervention included that staff were to remind and assist the resident with toileting needs every 2 hours.

Inspector observed the resident from 0900 h to 1215 h: During this time period, the resident was at breakfast, returned to the room, received morning fluid pass and returned to the dinning room for lunch. At no time during this period of observation was any staff observed to remind the resident to toilet or did staff offer assistance to toilet.
The care set out in resident # 838's plan of care was not provided. [s. 6. (7)]

16. Inspector 158 reviewed resident # 838's health care records. In regards to the resident's recreational and social program, records identified that it was the resident's preference to not go to large group activities or religious events. The activation assessment for this resident identified the resident to enjoy playing board games, and

that one-to-one sessions were to be provided. In addition, the resident was to be provided with daily reading materials.

Inspector reviewed the activation flow sheets for this resident from February 25 to March 8, 2013. Inspector noted there was no documentation of one-on-one activities. Inspector made multiple observations of this resident during the two-week Resident Quality Inspection. At no time, did the Inspector observe the resident engaged in one-on-one activity. In addition Inspector observed that in the resident's room, the reading material was layered in dust.
The care set out in the plan of care was not provided to the resident as specified in the plan [s. 6. (7)]

17. Inspector 158 observed that resident #041 used a fork to pick at food but did not eat the supper meal. No assistance or encouragement by staff was given to the resident during the meal service.
Inspector reviewed the resident's health care record and noted that the resident required extensive encouragement by staff to complete the meals and that assistance was to be provided when the resident was not eating independently.
The home did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

18. Inspector 158 observed the evening meal service and noted that resident # 017 picked at and played with the food presented throughout the meal service. The resident was observed to take several small bites but did not eat much of the meal. Inspector noted that no staff assistance or encouragement was given to the resident.

Inspector reviewed resident #017's health care records and noted in the plan of care the resident required extensive encouragement by staff to complete the meals and required staff assistance when the resident was not eating.
The home did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan [s. 6. (7)]

19. Inspector 196 observed resident #601 sitting in the dining room with hair dishevelled. Inspector reviewed the resident's plan of care and noted that staff were directed to remind the resident to comb the hair as part of the resident's hygiene and grooming procedure. In an interview, staff #018 confirmed that the resident did require reminders to "wash own face and hands, and comb hair and get dressed". Resident #601 was not provided with care as is specified in the plan of care. [s. 6. (7)]

20. Inspector 151 reviewed resident #0005's health record and most current plan of care. Inspector noted that the plan of care described the resident as follows: requiring limited assistance for toilet use, requiring a containment continence care product, independent with ambulation with the use of a walker and "can reach the toilet independently". In regards to mobility, the resident was described as independent with walking in hallway with walker and independent with bed mobility. For hygiene, the resident was requiring only cuing and guidance. In regards to communication, the resident was able to orally converse in both English and French

Inspector reviewed the resident's health care record and interviewed staff, both of these confirming the resident had a significant change in health status that affected the resident's ability to communicate, to ambulate and transfer, to do any activity of daily living without extensive staff assistance. In addition the resident was identified to have an infection and that the resident was palliative. None of these changes were reflected in the plan of care.

The resident's plan of care was not reassessed and revised when the resident's care needs changed or the care set out in the plan was no longer necessary. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 002, 003, 004, 005, 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)The following order(s) have been amended:CO# 002,001,003,004,005,006

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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:
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. Between the dates of February 25 and March 8, 2013, Inspector 151 made multiple observations of a specific resident's bed room. On all occasions, Inspector observed that the bed curtains in the resident's semi-private room did not provide for complete privacy in treatment for residents occupying the room. The curtains for the resident residing in the bed 1 location did not fit the railing going around the bed, leaving a six foot gap at the end of the bed. This left the resident in bed 1 exposed in the provision of treatment and care if anyone traversed the room or whenever washroom in this room was used. Inspector noted that the washroom was also accessible to two other residents in the next room.
The licensee has not fully respected and promoted the resident's right to be afforded privacy in treatment and in caring for his or her personal needs. [s. 3. (1) 8.]

2. During the initial tour of the home, from the hallway, Inspector 158 had direct view of resident #019 receiving morning care by staff. The resident's lower limbs and continence product were exposed while staff assisted the resident in dressing. No privacy with care was provided.
The home did not ensure that resident was afforded privacy in caring for his personal needs. [s. 3. (1) 8.]

3. During the initial tour of the home, from the hallway, the Inspector had direct view of resident #021 as receiving morning care by staff. Resident's lower limbs and continence care product were exposed while staff provided morning care.
The home did not ensure that resident was afforded privacy in caring for his personal needs. [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 to ensure that every resident is afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector 196 observed a medication administration pass. Inspector observed staff to remove two tablets of Tylenol from the medication package for the resident and put these into a container on the medication cart for discard. Staff informed the Inspector that the Tylenol medication did not appear on the E-Mar record as medication to be administered that day and so had to be removed from the pharmacy sealed packet. Inspector noted that the medication package did not have any notations on it to indicate the Tylenol was not to be administered.

Inspector reviewed the home's policy in regards to medication changes. Inspector noted in the licensee's policy: 12-10 that Staff are directed as follows: "On multi-dose strip packs, circle the medication, with red ink, and/or place "Change of Direction" sticker on each pack which contains the "Change of Direction medication". The medication pack the Inspector observed had no such markings or sticker.

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 failed to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with. [s. 8. (1)]

2. On March 4 and 5, 2012, Inspector 196 was told by a staff member that Personal Support Worker (PSW) staff had applied a prescription cream to a resident's skin. In an interview, ADOC confirmed that the home's policy is that only registered nurses or registered practical nurses are to apply topical prescription medications to residents. ADOC confirmed that despite their policy, the practice of delegating application of topical medications to PSWs is sometimes being done: "they are not to do this".

The home failed to ensure that the plan, policy, protocol, strategy or system instituted was complied with. [s. 8. (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 to ensure that any plan, policy, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act and is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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 :

1. On February 26, 2013, Inspector 151 toured the fourth floor of the home and found the following: in the resident's washroom the grab bar to assist the resident off the toilet was found to have smeared dried feces. On this same day, after seeing that Housekeeping had serviced this room, Inspector returned to the room and observed the grab bar was in the same state.

On February 26, 2012, Inspector 151 toured the home and found the following in a resident's washroom:brown liquid splatter on the wall and floor near the toilet and that the plastic call bell cord had a heavy accumulation of dust and dirt. Inspector returned to the room after it was observed that Housekeeping had serviced the room. The splatter was no longer there, however the pull cord remained in the same state. Inspector 151 returned to the room on March 1, 2013 and found the pull cord to be in the same state.

The licensee did not ensure that the home, furnishings and equipment are kept clean and sanitary [s. 15. (2) (a)]

2. On March 4, 2013, Inspector 158 observed that the medication refrigerator located on a home unit contained individually ordered insulin for residents, dietary Resource supplement, loosely wrapped ham sandwiches. Inspector noted that the interior of the refrigerator was soiled with accumulated grime and dirt.
The licensee failed to ensure that, (c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (a)]

3. Inspector 196 toured the the home and observed the following: water stained ceiling tiles on 6th floor, the ceiling above the tub in the 5th floor spa room had paint peeling and water damage, and, the spa room shower corners were stained and the room had a musty odour. In addition, in a resident's room, the shared washroom had gouges and paint missing on the wall surface.

The licensee failed to ensure that, (c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

4. Inspector #158 observed the mattress on a resident bed to be sagging and lumpy and the mattress on bed 2 of this same room to have cracks and holes from missing mattress foam.

The licensee failed to ensure that, (c) 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 to ensure home, furnishings and equipment are kept clean and sanitary and that home furnishings and equipment are maintained in a safe condition and in a good state of repaire, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector 158 observed resident # 838 at 1000 h and again at 1515 h. On both of these observation, resident was noted to have food debris lodged in the teeth and that the resident had halitosis. The resident's plan of care identified that although the resident was independent with oral care the resident did require encouragement and assistance with set up.
The home did not ensure that the resident received oral care to maintain the oral tissue, including mouth care the morning of February 26, 2013. [s. 34. (1) (a)]

2. In an interview, DOC confirmed the home does not have a program, process or procedure that offers residents an annual dental assessment and other preventive dental services.
In an interview, Staff #028 confirmed residents are not routinely offered an annual dental assessment. Staff stated that only when concerns arise will the staff assist the resident with making arrangements for dental care.
The home did not ensure that the resident was offered an annual dental assessment and other preventive dental services. [s. 34. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident receives oral care to maintain the oral tissue, including mouth care in the morning and the evening and that each resident is offered an annual dental assessment, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. Inspector reviewed the home's policies and procedures in regards to skin and wound management. This policy is reflective of the legislated requirements in relation to wound care and this policy is explicit in directing staff that the resident who has altered skin integrity is to have weekly assessment of their wounds. Resident #0817 was noted to have 2 pressure ulcers. Inspector reviewed the resident's wound care assessments for the last 3 months and and noted the following:
- In February 2013, it is noted that there is a 14 day interval between Feb.6 - 22, 2013 where there is no assessment.
- In January 2013, it is noted there is a 14 day interval between January 16-31, 2013 where there is no wound assessment.
- In January 2013, there is a 14 day interval between Dec. 25, 2012 and January 9, 2013 where there is no wound assessment. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures resident #0817 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #7: 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:

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; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. Inspector 158 reviewed the health care record for resident #838; including the assessments, progress notes, and flow sheets.
The continence assessment completed on December 6, 2012 by staff #004 was blank except for identifying that the resident was continent. The Resident Assessment Protocol(RAP) identified that the resident was at risk for incontinence related to occasional incontinence and that the resident wore a product to try and manage incontinence.
Inspector noted documentation in the resident's progress notes indicating the resident had had episodes of urinary incontinence in the last few months. Flow sheet review showed increasing frequency in the episodes of incontinence. Flow sheets indicated that on a few occasions the resident required an incontinent product.
In an interview, Staff #010 confirmed the resident was occasionally incontinent of urine and refused to wear a product. The PSW stated that the resident was not on a toileting schedule and pericare was provided to the resident when incontinent.
On February 25, March 1 and March 4, 2013, the Inspector observed that the floor beside the resident's bed was wet, sticky and smelling of urine.
An assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions was not completed. [s. 51. (2) (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 that ensures all residents who are incontinent and, specifically for resident #838, receive 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, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. Inspector noted the resident population on the 5th floor included residents who are most severely afflicted with dementia. On March 7, 2013, at 1400 h Inspector 151 observed in the dining room on 5th floor, that there were 16 residents in the dining room sitting at tables where there was fluids and food on the tables easily accessible to them. Two of the residents had thickened fluids in front of them. Inspector noted there was no staff present in the dining room to monitor the residents.

In addition, Inspector observed a resident at the entrance to the dining room using the door frame to try to stand from the wheel chair. Inspector called staff to the dining room and this staff person confirmed the resident attempting to stand was at a high risk for falls and should not be engaged in this activity without staff supervision.
The home did not ensure the monitoring of all residents during meals [s. 73. (1) 4.]

2. Inspector 158 observed the supper meal service on the 5th floor on February 26, 2013. Inspector noted that food was plated and placed at the table place for resident #029 at 1735 h. Resident was not seated at table. Inspector found the resident sitting in a w/c in the resident's bedroom. At 1805 h, staff portered the resident to the dining room and placed the resident at the table. The resident was observed to eat the plated food which had been sitting on the table for 30 minutes. No staff offered to replace or re-therm the food.
The home did not ensure that the food served to resident was at a temperature that was both safe and palatable to the resident. [s. 73. (1) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that will ensure that all residents are monitored during the entire meal and snack service and that food and fluids are served at a temperature that is both safe and palatable for the residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. On February 26, 2013, Inspector 151 toured the home and found that in resident #638's room there was a lingering odor of urine, the floor around the resident's bed was found to be soiled with dried urine, the resident's washroom had urine on the floor and dried urine accumulation around the base of the toilet. On March 1, 2013, Inspector 151 again toured the room and found that the lingering odor of urine persisted and that the condition of the resident's washroom remained the same. Resident's roommate stated that the room and bathroom were consistently in this state and that he was bothered by it. The home did not address the incident of lingering offensive odors. [s. 87. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures the home addresses all incidents of offensive odors, and, specifically, the issue presenting for resident #638, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.

2. Access to these areas shall be restricted to,

i. persons who may dispense, prescribe or administer drugs in the home, and

ii. the Administrator.

3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. On March 1, 2013, at 0815 h, Inspector observed a medication pass. Inspector noted that the medication cart was in the hallway out of view of any staff. Inspector noted that Staff #030 was in a resident's room with the door closed. Inspector observed the keys to the cart on top of the cart and accessible to anyone. Included in the ring of keys were keys to the cart itself, the narcotic box in the cart and the medication room on the unit. The keys were on the cart and out of view of any staff for 4 minutes before staff exited the room and came back to the cart. The licensee did not ensure that steps were taken to ensure the security of the drug supply. [s. 130. 1.]

2. On March 4, 2013, the Inspector observed a medication pass. On two separate occasions during the inspector observation, the medication cart was not locked while the RPN administered medications to the residents in their room. On both of these occasions and while the RPN was in the residents' rooms, the staff person had no clear view of the cart.
The licensee did not ensure that all areas where drugs are stored were kept locked at all times. [s. 130. 1.]

3. On March 6, 2013 at 1100hrs, on 2nd floor, Inspector #196 observed staff member #032 stocking the medication room with government stock medications. In an interview with the Inspector, Staff #032 confirmed that this staff was not a member of the registered nursing staff nor a pharmacist. In an interview, Staff#032 confirmed that that while [staff #032] did not have keys to the medication rooms on each unit, this staff person did have a key to the government medication stock room . It was staff #032's job to restock each unit with the stock medications at regular intervals.
The licensee did not ensure the security of the drug supply, specifically, did not restrict access to these areas by those not able to dispense, prescribe or administer drugs in the home. [s. 130. 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to ensure the security of the drug supply, including that all areas where drugs are stored shall be kept locked at all times, when not in use and including that access to these areas shall be restricted to, persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007, 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 February 25, 2013, Inspector 151 observed the evening meal service. Inspector polled the residents in regards to meals and food service satisfaction. Resident #044 stated: "often there is nothing left that I like". Resident #045 stated that "the food was good but what I hate is when they run out of stuff".

In an interview, Staff #033 told Inspector 151 that on frequent occasions there was an insufficient quantity of food prepared to meet the needs of the residents and that at these times they were advised to use a smaller scoop size than the recommended ones to plate the food. In addition, Staff #033 stated that the home runs out of favorite items for the residents: peanut butter, jam, All Bran Buds.

Subsequently, Inspector interviewed dietary staff #034 who confirmed staff had been directed on an infrequent basis to alter the scoop size because there was insufficient quantity of food prepared. Staff #034 confirmed that on occasion, the home does run out of preferred entree choices.

The home did not ensure that residents are provided with food and fluids that is adequate in quantity. [s. 11. (2)]

WN #12: 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. On March 4, 2013 at 0905 h and 1100 h, Inspector 158 observed resident # 838 to be resting in bed and that the call bell was located behind the head board and on the floor. The call bell was not accessible to the resident.
The home did not ensure that the resident-staff communication response system was accessible to the resident at all times. [s. 17. (1) (a)]

2. Inspector 151 made multiple care observations in regards to resident #717. Inspector noted that on 2 of 7 observations, the resident's call bell was found on the floor between the two beds in the room. In an interview, staff #035 confirmed the Inspector's observations. Staff #035 stated that the call bell was on the floor like this since the beginning of the day shift.
The licensee did not ensure that the resident-staff communication response system was easily seen and accessible by residents, staff and visitors at all times. [s. 17. (1) (a)]

WN #13: The Licensee has failed to comply with LTCHA, 2007, 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).

Findings/Faits saillants :

1. Inspector 158 reviewed resident #838's health care records and noted that staff #036 had documented a report made to her by resident #838 alleging that the PSW working that evening was too rough with the resident while giving care. The documentation further identified that staff #036 had spoken with the PSW alleged to have been rough with the resident. Inspector 158 reviewed the 24 hour report for that day and noted that there was no communication of the incident. Inspector 158 spoke to the Director of Care (DOC) who confirmed that management was not aware of the resident's allegation of abuse. DOC stated that she was on-call at the time of this incident and she did not receive any notification of the incident by anyone.

Inspector 151 reviewed the home's policy on abuse: reference: Operations:Resident Abuse and Neglect, Version July 2012. On page 2, the policy is explicit in directing staff to "immediately report (verbally) any suspected or witnessed abuse to the Administrator, Director of Care or designate".

The licensee did not ensure that its abuse/neglect policy to promote zero tolerance of abuse or neglect of residents was complied with. [s. 20. (1)]

WN #14: 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:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. Inspector 151 reviewed resident # 818's 's health care record and noted that the resident had pain management as an identified concern. Inspector reviewed the resident's plan of care and noted that there were no other interventions other than to provide pain medication. There was no mention of any other interdisciplinary assessment with respect to special treatments and interventions for the resident's pain.
The plan of care is not based on an interdisciplinary assessment with respect to the resident's special treatments and interventions [s. 26. (3) 18.]

WN #15: 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. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. Inspector 151 reviewed the home's document regarding the home's annual review of the staffing plan titled :"Sufficient Staffing". Inspector noted that there was no reference identifying the summary of the changes made and the date that those changes were implemented. Interview with the Administrator and Director of Care confirmed that this information is not available in any other documentation. The licensee does not have a record of annual evaluation of the staffing plan that includes a summary of the changes made and the date that those changes were implemented. [s. 31. (4)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. Inspector 151 made multiple observations of resident #717 and noted that on 6 of 7 days of direct observations, the resident was found to be unshaven. Staff interviewed confirmed that it was their responsibility to shave the resident and that it was not usual for the resident to resist care.

The resident did not receive individualized personal care, including hygiene care and grooming on a daily basis [s. 32.]

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

Specifically failed to comply with the following:

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. On February 26, March 1, March 5 and March 8, 2013, Inspector 158 observed that resident #784's fingernails were long, jagged and with soil build up. Inspector reviewed the resident's plan of care and noted, under the bathing section, that the resident required total assistance of one staff to clean, trim and file nails weekly. Inspector reviewed the resident's flow sheet for that week and noted the resident did receive a weekly bath, however, nail care was not documented as having been provided.
The home did not ensure that resident # 784 received fingernail care, including the cutting of fingernails. [s. 35. (2)]

2. On February 25, March 1, March 5 and March 8, 2013, the Inspector observed that resident #838's fingernails were long, jagged with soil build up. Inspector reviewed the resident's plan of care and noted under the bathing section, the resident required the total assistance of one staff to clean, trim and file nails weekly. Inspector reviewed the resident's flow sheet for that week and noted the resident did receive a bath, however, nail care was not documented as having been provided.
The home did not ensure that resident # 838 received fingernail care, including the cutting of fingernails. [s. 35. (2)]

WN #18: 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,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. Inspector 151 observed the evening meal service on February 25, 2012. Inspector observed that a tray service was plated and transported down the hallway without all food and fluids being covered in transit. The home did not ensure that all food and fluids are prepared, stored, and served using methods which prevent adulteration, contamination and food borne-illness. [s. 72. (3) (b)]

WN #19: The Licensee has failed to comply with LTCHA, 2007, s. 79. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector 151 noted that the contact information for the Director was not posted as required.
The licensee did not ensure the written procedure 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 was posted. [s. 79. (3) (f)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. On February 28, 2013, Inspector 158 observed the linen carts servicing 4 West and noted several cloths used for resident pericare had ragged edges, were thread-bare and were rough in texture. On March 1, 2013 at 0915h, the Inspector observed 4 further examples of frayed and thread bare pericare cloths on the linen cart.
On February 25, 2013, Inspector 158 observed that the bottom fitted sheets for resident # 037 and resident #0782's beds were thread bare, stained and with holes.
On March 1, 2013, the Inspector observed that two bottom fitted sheets which were going to be used to make residents beds by staff on the 5th floor were thread bare, stained and with holes.
On March 7, 2013, Inspector #196 observed the pillow case on bed a resident's bed to be thread bare.

The home has not ensured that linen was maintained in a good state of repair or free from stains. [s. 89. (1) (c)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On March 4, 2013,at 1330 h, Inspector 158 observed that the 4th floor medication refrigerator's temperature was registering at 27.1 Celcius (C). Inspector reviewed the refrigerator's temperature logs and noted temperatures were not consistently taken and that, in the log, under the column "current temperatures", values recorded in February 2013 ranged from 25.4 to 29.5 C. In this same log, under the column titled "minimum temperatures", the values recorded ranged from -18.5 to 21.9 Celsius. Inspector reviewed the contents of the refrigerator and noted several vials of insulin prescribed for residents being stored here. Inspector reviewed the information on the insulin packages and noted the insulin is to be stored at 2-8 C.
The home did not ensure that medication was stored in an area that complies with manufacturer's instructions for the storage of the drugs for refrigeration. [s. 129. (1) (a)]

2. On March 4, 2013, Inspector 158 observed the medication pass on the 6th floor and noted the following were on top of the cart:medications Metamucil and Lactulose , loaded Insulin pens, and medications for resident #025. These remained on the top of the cart in the hallway while the staff person entered resident rooms to administer them their medications. While in the resident's rooms, the staff person did not have direct view of the medication cart.
The home did not ensure that the medications were stored in an area of the medication cart that was secure and locked. [s. 129. (1) (a)]

3. On March 5, 2013 , Inspector 196 reviewed the contents of the East side medication cart on the 3rd floor of the home. The Inspector noted a purse in the lower drawer of the cart. Staff #038 identified the purse as belonging to her.
The licensee failed to ensure that, (a) drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies. [s. 129. (1) (a)]

4. On March 5, 2013 , Staff #024 showed Inspector 196, two opened jars of prescription topical medication labelled "Clotrimaderm 1%" for resident #039 kept in the resident's bedside drawer. In addition, Staff #024 showed the Inspector resident #041's prescription topical cream "Emocort 1%" in the drawer at this resident's bedside. Neither of these residents had physician orders for self administration of medications. The home did not ensure that medications were stored in an area exclusively for drugs and drug related supplies and that these medications were kept secured and locked. [s. 129. (1) (a)]

WN #22: 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:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. On March 4, 2013, Inspector 158 observed a medication pass. Inspector observed staff #031 to pick up a medication that had fallen on the floor and to give it to the resident. Resident was observed to swallow the medication.
The licensee did not ensure that all staff participate in the infection control program. [s. 229. (4)]

2. On March 5, 2013, the Inspector 158 observed damp peri towels strewn across the back of the toilet and on the floor at the base of the toilet in a resident's washroom. When questioned by the Inspector in regards to this situation, housekeeping staff stated the towels were an effort to contain urine on the floor. Inspector 151 interviewed the Manager for Housekeeping and was advised the housekeeping routine is to clean the resident's room and bathroom once per day.

The licensee did not ensure that all staff participate in the infection control program. [s. 229. (4)]

3. On February 25, 2013 at 0905h, the Inspector 158 observed three wet cloths on the floor by the toilet in the bathroom shared by four male residents. The floor around and in front the toilet was sticky and wet. The Inspector made a further observation of the room after it was noted that housekeeping had serviced the room. One saturated towel remained on the back of the toilet and the floor remained sticky in front of the toilet.

The licensee did not ensure that all staff participate in the infection control program. [s. 229. (4)]

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS			
REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 19. (1)	CO #002	2011_029134_0003	151

Issued on this 31 day of May 2013 (A2)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Monique G. Berger