Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELISSA CHISHOLM (188), LAUREN TENHUNEN (196), MARGOT BURNS-PROUTY (106)
Inspection No. / No de l'inspection :	2012_099188_0047
Log No. / Registre no:	S-001105-12
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 13, 2013
Licensee / Titulaire de permis :	ST. JOSEPH'S CARE GROUP 35 NORTH ALGOMA STREET, P.O. BOX 3251, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	HOGARTH RIVERVIEW MANOR 300 LILLIE STREET, THUNDER BAY, ON, P7C-4Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PAULINA CHOW

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to residents as specified in the plan. Specifically, the licensee shall ensure that the care set out for resident #88446 and #88419 is provided to the residents as specified in the plan.

Grounds / Motifs :

1. Inspector observed resident #88419 and resident #00008 eating their lunch meal in their respective rooms, alone and without the presence of staff. Plans of care for both residents were reviewed. Both residents require supervision for eating related to their risk of choking. Neither of these residents were being provided with care as was specified in their respective plans of care. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. (196)

2. Resident #88446 plan of care was reviewed and specifically the interventions related to fall prevention. On December 6, 2012, inspector noted the interventions related to fall prevention were not being followed. Staff member S#103 was asked about these interventions and confirmed they were not currently being followed. The licensee failed to ensure the care set out in the plan of care is provided to the resident as specified in the plan. (106)

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

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Order / Ordre :

The licensee shall ensure a resident is restrained by the use of a physical device only once all the requirements as expressed in s.31(2) of the Act are satisfied

Grounds / Motifs :

1. Inspector observed on November 30, 2012 and on December 5, 2012 that resident #88419 had all four side rails elevated while lying in bed. Interviews were conducted with staff members who identified that all four side rails are used when the resident is in bed and that the resident is unable to release or remove the side rails. The most recent MDS assessment, under the section of devices and restraints, noted the use of daily full bed rails on all open sides of the bed. The care plan dated November 5, 2012, did not include the use of all four side rails as a restraint device, but did include the intervention of "all rails up" as a fall prevention measure. A review of the resident's health care record was done and there was no order for the use of all four side rails and there was no signed consent documents located. The side rails are being used while this resident is in bed, yet the requirements for the use of a physical restraint has not been met. The licensee failed to ensure that the use of a restraint by a physical device is included in the resident's plan of care only if all the requirements are satisfied. (196)

2. Inspector observed on November 27, 2012 and December 4, 2012 that resident # 88398 had a lap belt on while sitting up in the wheelchair. Inspector asked the resident to remove the belt and the resident was unable to complete the task. Inspector spoke with staff who identified that some days the resident is able to release the device and other days the resident has more difficulty due to cognitive limitations. Inspector noted that this physical device is not included in the residents plan of care, there is no order for application of the physical device, no signed consent, no assessment indicating what alternatives have been tried was available, and the significant risk the resident poses to themselves or others if the device was not used was not located. The licensee failed to ensure that the use of a restraint by a physical device is included in the resident's plan of care only if all the requirements are satisfied. (188)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

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

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

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

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

Issued on this 13th day of March, 2013

Signature of Inspector / Signature de l'inspecteur :

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

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 13, 2013	2012_099188_0047	S-001105-12	Resident Quality Inspection

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET, P.O. BOX 3251, THUNDER BAY, ON, P7B-5G7

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

HOGARTH RIVERVIEW MANOR
300 LILLIE STREET, THUNDER BAY, ON, P7C-4Y7

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

MELISSA CHISHOLM (188), LAUREN TENHUNEN (196), MARGOT BURNS-PROUTY (106)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 26th-30th, December 3-7, 2012

The following logs were reviewed as part of this Resident Quality Inspection: S-000906-12, S-001050-12, S-001105-12, S-001244-12.

During the course of the inspection, the inspector(s) spoke with the Vice-President of Long Term Care Services, the Director of Care (DOC), the Clinical Care Coordinator, the RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Finance Manager, Dietary Aides, the Dietitian, the Food Service Supervisor, Activation staff, Recreationalist, Enrichment Coordinator, Resident Council President, Family Council President, Residents and Families

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

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Accommodation Services - Laundry

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. Inspector reviewed the plan of care for resident #88398. Inspector noted that it identifies in one section related to nutritional status that the resident is on a certain textured diet and in a different section, related to eating, it identifies the resident on a different textured diet. The plan of care provides conflicting and unclear direction to staff relating to the resident's diet texture. The licensee failed to ensure the plan of care provides clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. Resident #88419 was observed in their wheelchair with a front closing seat belt in place. The resident was able to undo the seat belt on their own when requested. The care plan dated November 5, 2012 was reviewed and did not include the use of a front closing seat belt while the resident was up in the wheelchair. The care that was provided to the resident was not included in the written plan of care and therefore the plan did not give clear directions to staff and others who provide direct care to this resident. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. The most recent MDS assessment for resident #88419 identifies the resident's various activity interests. An interview was conducted with staff member S#102 on December 6, 2012 and the resident's activity interests were determined. There was an horticulture program scheduled on December 3rd and manicures on December 5, 2012 and neither activities were offered to the resident, despite these being identified as within the resident's interests. The care plan dated November 5, 2012 was reviewed and did not include interventions regarding the resident's interests and therefore did not provide clear directions to those providing care. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

4. Resident #88446 plan of care was reviewed and specifically the interventions related to fall prevention. On December 6, 2012, inspector noted the interventions related to fall prevention were not being followed. Staff member S#103 was asked about these interventions and confirmed they were not currently being followed. The licensee failed to ensure the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

5. Inspector observed resident #88419 and resident #00008 eating their lunch meal in

their respective rooms, alone and without the presence of staff. Plans of care for both residents were reviewed. Both residents require supervision for eating related to their risk of choking. Neither of these residents were being provided with care as was specified in their respective plans of care. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

6. The care plan dated November 5, 2012 for resident #884129 was reviewed and included the interventions of supervision during meal service related to a risk for choking. An interview was conducted with staff member S#100 on December 4, 2012 and it was reported that this resident is not at risk for choking. On December 6, 2012 an interview was conducted with staff member S#101. According to this staff member, this resident is no longer considered at risk for choking and that the risk was at risk when ill in the recent past and the care plan is to be updated when the resident's condition changes. The licensee failed to 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 the resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. Inspector observed on November 30, 2012 and on December 5, 2012 that resident #88419 had all four side rails elevated while lying in bed. Interviews were conducted with staff members who identified that all four side rails are used when the resident is in bed and that the resident is unable to release or remove the side rails. The most recent MDS assessment, under the section of devices and restraints, noted the use of daily full bed rails on all open sides of the bed. The care plan dated November 5, 2012, did not include the use of all four side rails as a restraint device, but did include the intervention of "all rails up" as a fall prevention measure. A review of the resident's health care record was done and there was no order for the use of all four side rails and there was no signed consent documents located. The side rails are being used while this resident is in bed, yet the requirements for the use of a physical restraint has not been met. The licensee failed to ensure that the use of a restraint by a physical device is included in the resident's plan of care only if all the requirements are satisfied. [s. 31. (1)]

2. Inspector observed on November 27, 2012 and December 4, 2012 that resident # 88398 had a lap belt on while sitting up in the wheelchair. Inspector asked the resident to remove the belt and the resident was unable to complete the task. Inspector spoke with staff who identified that some days the resident is able to release the device and other days the resident has more difficulty due to cognitive limitations. Inspector noted that this physical device is not included in the residents plan of care, there is no order for application of the physical device, no signed consent, no assessment indicating what alternatives have been tried was available, and the significant risk the resident poses to themselves or others if the device was not used was not located. The licensee failed to ensure that the use of a restraint by a physical device is included in the resident's plan of care only if all the requirements are satisfied. [s. 31. (2) 1.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. A "Bladder and Bowel Continence Assessment" for resident #88383 was completed. This assessment was reviewed by the inspector and it indicates that the resident is incontinent of both bladder and bowel and requires assistance with toileting. The plan of care that was found in the PSW binder for resident #88383 was also reviewed. The plan of care indicates that the resident #88383, is independent and does not require any assistance with toileting. The licensee failed to ensure that the resident's plan of care is based on an interdisciplinary assessment of the resident's continence, including bladder and bowel. [s. 26. (3) 8.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring the plan of care is based on an interdisciplinary assessment of the resident's continence, including bladder and bowel, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. Inspector reviewed the home's minimizing of restraining policy titled "Least Restraint Use Toolkit" dated December 2007. Inspector noted this policy does not include any reference to the LTCHA 2007 or Ontario regulations 79/10. Inspector noted this policy does not identify who has the authority to apply or release a physical device. Further, inspector noted the policy does identify which physical devices are permitted in the home, however, the list includes devices (magnetic restraints which require a separate key to release) which are prohibited under the LTCHA 2007. The inspector noted it is identified in the policy that some physical devices may be considered PASDs, however, the policy fails to identify how consent for PASDs is obtained. The policy fails to include any direction relating to restraining a resident under the common-law duty as described in section 36 of the Act. The licensee failed to ensure that there is a written policy to minimize the restraining of residents and to ensure any restraining that is necessary is done in accordance with the Act and regulations. [LTCHA 2007, S.O. 2007, c.8, s.29(1)(a)](188)
2. After providing the inspector with the policy dated December 2007 a draft version of the new minimizing of restraining policy was provided. Later the same day a third copy was provided this time the DOC identifying the new policy was approved and is the current policy. Inspector spoke with three staff members who were unaware that the restraint policy was updated and had not been provided any direction relating to this new policy, this newly approved policy was not reviewed by the inspector. [s. 29. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring there is a written policy to minimize the restraining of residents and to ensure any restraining that is necessary is done in accordance with the Act and regulations, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

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Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector reviewed the home's staffing plan. Inspector noted that one comprehensive staffing plan identifying how many staff work on each unit on each shift was not available. Instead a summary of the number of nursing staff members who work on each shift throughout a week was provided along with several other schedules and documents. It was identified that currently full time RPNs switch units every three months, however in 2013 the home will begin primary assignment and this will no longer occur. Inspector noted that no formal back-up staffing plan was provided. In discussion with the home's DOC it was identified that the home attempts to replace any absent employees and if they are unable to replace through the home's call-in process that it is then up to the individual RN supervisor working on that shift to determine how the staffing should be re-distributed. Further, it was identified while speaking with the DOC that although a template for evaluating the home's staffing plan has been developed the staffing plan has not previously been evaluated. Inspector inquired if residents assessed safety and care needs are the same on each unit because the staffing complement is identical for each unit. It was reported that the resident care needs are not the same on each unit and the home will be considering resident's assessed care and safety needs in the future when evaluation of the staffing plan occurs. The licensee failed to ensure there is a written staffing plan for the organized program of nursing and personal support services that meets the requirements set out in the Act and the Regulations. [s. 31. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring their is a written staffing plan that is based on residents' assessed care and safety needs and includes a back-up plan for nursing and personal care staffing, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. Inspector observed on December 3 and 4, 2012 following lunch that resident #88398 was in bed with all four quarter rails in the up position. Inspector noted that direction to have all four rails up was included in the resident's plan of care. It was identified to the inspector by two staff members that the bed rails are used for positioning and would be considered a PASD. Inspector noted approval for use of the physical device was not available, nor was a signed consent. Further no alternatives to the use of the PASD were documented. The staff members confirmed that they do not obtain consent for bed rail use, nor is approval documented other than the directions to staff in the plan of care. The licensee failed to ensure the use of a PASD to assist a resident with a routine activity of living is included in the resident's plan of care only if all requirements are satisfied. [s. 33. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring the use of a PASD to assist a resident with a routine activity of living is included in the resident's plan of care only if all requirements are satisfied, 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,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. Resident # 88383's Daily Resident Care Record for Sept, Oct., Nov. and Dec. 1-4, 2012, were reviewed by inspector. The resident was assessed by staff as being incontinent on the majority of days. On December 4, 2012, two staff members reported to inspector that the resident is independent for toileting and another staff member stated that resident #88383 requires assistance "after the fact", meaning the resident is assisted only when incontinent and is not currently on a toileting program. The plan of care for resident #88383 under the section titled "Toileting", indicates the resident is independent for toileting. The licensee failed to ensure that each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented. [s. 51. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring each resident who is incontinent has an individual plan to promote and manage bowel and bladder continence and that the plan is implemented, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The most recent MDS assessment for resident #88419 was reviewed and identified the resident as requiring total dependence for transfer with two person assist. According to the resident, staff providing physical assistance is required to attend the activities. A review of the recreation program flow sheets was done and it was determined that during the month of November 2012, this resident was identified as participating or being approached to participate in an activity 13 times out of a total 80 scheduled programs. The flow sheets for December 1st to 6th, 2012 identified the resident as not participating in any activities and having not been approached to attend any activities. This resident requires the assistance of staff members to participate in the home's activities and is not being approached to attend, nor being assisted to attend. The licensee failed to ensure that the program includes assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. [s. 65. (2) (f)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring assistance and support is provided to residents to permit them to participate in activities that may be of interest to them, if they are not able to do so independently, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes

Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. Inspector reviewed resident #88398 weights for the last six months. Inspector noted several of these weight changes meet the requirements for interdisciplinary assessment based on weight loss and gain greater than the established percentages. Inspector reviewed the resident's health care record and noted that no interdisciplinary assessment related to the resident's weight changes was completed. Inspector spoke with staff who identified that when a resident experiences a significant weight gain or loss a referral to the dietitian should be initiated by the registered nursing staff. Inspector noted no referrals to the dietitian had been initiated for resident #88398. The licensee failed to ensure that a resident who's weight change exceeds the established percentages for interdisciplinary assessment is assessed using an interdisciplinary approach and that actions are taken and that outcomes are evaluated. [s. 69.]

2. Inspector reviewed resident #88439 weights since the resident's admission. Inspector noted several of these weight changes meet the requirements for interdisciplinary assessment based on weight loss and gain greater than the established percentages. Inspector reviewed the resident's health care record and noted that no interdisciplinary assessment related to the resident's weight changes was completed. Inspector spoke with staff who identified that when a resident experiences a significant weight gain or loss a referral to the dietitian should be initiated by the registered nursing staff. Inspector noted no referrals to the dietitian had been initiated for resident #88439. The licensee failed to ensure that a resident who's weight change exceeds the established percentages for interdisciplinary assessment is assessed using an interdisciplinary approach and that actions are taken and that outcomes are evaluated. [s. 69.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring residents who have a weight change exceeding the established percentages for interdisciplinary assessment are assessed using an interdisciplinary approach and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. On December 4, 2012, inspector observed that the residents on Willow Grove were not offered a between-meal morning beverage. On December 5, 2012, at 09:45h, inspector observed the beverage cart in the Willow Grove kitchen area. Between 09:45h and 11:20h the beverage cart remained in the Willow Grove kitchen. During this time inspector did not observe staff take the beverage cart travel down either of the corridors on Willow Grove to offer a morning beverage to residents who were in their rooms. The licensee failed to ensure that each resident is offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner. [s. 71. (3) (b)]

2. On December 4, 2012, inspector interviewed resident #88100 and a family member of resident #88101. Both the resident and the family member told the inspector that there was no beverage offered between breakfast and lunch on December 4, 2012. An interview was conducted with staff member S#104 at 11:35h on December 4, 2012 and it was determined that not all residents were offered with a morning beverage on the Spruce Grove unit. Staff member S#104 stated "no time to go around with the cart". The licensee failed to ensure that each resident is offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner. [s. 71. (3) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring each resident is offered a minimum of a between-meal beverage in the morning and afternoon and beverage in the evening after dinner, to be implemented voluntarily.

WN #11: 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).

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:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. On November 30, 2012 at 12:45h, on Cedar Grove, resident #88419 and resident #00008 were observed eating their lunch meal in their respective rooms, alone and without the presence of staff. The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, the monitoring of all residents during meals. [s. 73. (1) 4.]

2. On December 6, 2012, during the dinner service in Spruce Grove resident #88446 called inspector over to their table and reported that the food was cold. Inspector observed that the residents were served an entree what appeared to be pasta and Swedish meat balls. A family member who was at the table assisting another resident touched the food of the resident, that they were assisting, and stated that it was cold. The licensee failed to ensure that food and fluids are served at a temperature that is both safe and palatable to the residents. [s. 73. (1) 6.]

3. Inspector reviewed the plan of care for resident #88398. Inspector noted that this resident requires assistance with eating. Inspector observed on December 6, 2012 during the lunch meal service that the resident did not receive any assistance. Inspector observed for approximately forty minutes while the resident attempted to feed themself, on occasion bringing a partially filled spoon up to the resident's lips however mostly bringing an empty spoon. While clearing the table, of other residents completed meals, a staff member was observed to encourage the resident to continue eating, however no physical assistance, as indicated in the plan of care, was provided. Prior to leaving the dining room inspector spoke with a staff member who confirmed that the resident should have assistance with eating. The licensee failed to ensure that residents are provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. [s. 73. (1) 9.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance all residents are monitored during meals, and assistance and encouragement is provided to residents who require it, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. Inspector observed on November 27 and December 4, 2012 during multiple observations that resident #88398 had a lap belt applied while up in the wheelchair. Inspector noted that this lap belt was quite loose, and when pulled tight by the inspector there was approximately 10 cm of space between the belt and the resident. The licensee failed to ensure that the physical device is applied according to the manufacturer's directions. [s. 110. (1) 1.]

2. Inspector reviewed the health care record for resident #88396. Specifically, inspector reviewed the November 2012 medication administration record (MAR) where it was reported that registered staff sign to indicate on-going assessment of the resident's physical restraint. Inspector noted that the MAR only included one signature for each day and this signature was reported to be that of day shift registered staff. Inspector noted that the resident is not reassessed and the effectiveness of the restraining evaluated every eight hours by a member of the registered nursing staff. [s. 110. (2) 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 ensuring physical devices used for the restraining of residents is applied according to the manufacturer's directions and that the resident is reassessed and the effectiveness of the restraining evaluated every eight hours by a member of the registered nursing staff, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. On Dec 5, 2012, inspector noted that a bottle of Extra Strength Tylenol was in the medication cart for Willow Grove. Staff member S#106 stated the the bottle of Extra Strength Tylenol was brought in by the family and not from government stock or provided by the pharmacy service provider. The licensee failed to ensure that no drug is acquired, received, or stored by or in the home unless the drug has been provided by the pharmacy service provider or the Government of Ontario. [s. 122. (1)]

2. On December 4, 2012, inspector reviewed the contents of the Birch Grove medication cart. Within the cart was a large bottle of Calcium Carbonate 500mg and bottle of Vitamin D 1000 iu, these medication bottles did not contain a pharmacy label. Staff member S#105 reported to the inspector that the family of resident #88102 have brought these medications in to use as it costs less to purchase elsewhere and not from the provider. The licensee failed to ensure that no drug is acquired, received, or stored by or in the home unless the drug has been provided by the pharmacy service provider or the Government of Ontario. [s. 122. (1)]

3. Inspector reviewed the medication carts for both Spruce Grove and Birch Grove. Inspector noted the Birch Grove medication cart contained medications not labeled with a pharmacy provided label. Inspector spoke with staff member S#103 who confirmed that some residents have family members bring in medications and these are not dispensed through the home's pharmacy service provider or government pharmacy. The licensee failed to ensure that no drug is acquired, received, or stored by or in the home unless the drug has been provided by the pharmacy service provider or the Government of Ontario. [s. 122. (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 ensuring no drug is acquired, received, or stored by or in the home unless the drug has been provided by the pharmacy service provider or the Government of Ontario, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. On December 5, 2012, Inspector reviewed the contents of the Cedar Grove medication stock cupboard. The cupboard contained several types of unopened stock medications that were past their expiry dates. These included:
- Tylenol plain - 12 bottles, expiry date of Oct. 2012
- Entrophen 650mg - 11 bottles, expiry date of Oct. 2012
- Novasen 325mg - 7 bottles of 100 tablets, expiry June 2011
- Atasol 325mg -16 bottles, expiry Oct. 2012
- Slow K 600mg - 6 bottles, expiry April 2011
- Isopto tears 1% - 6 bottles expiry date of Feb. 2012, and 6 bottles expiry date of Oct. 2011

The licensee failed to ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. [s. 124.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring drugs obtained for use in the home are obtained based on resident usage and that no more than a three-month supply is kept in the home at any time, to be implemented voluntarily.

WN #15: 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 December 5, 2012, inspector observed 27 vials of Haloperidol that had expired June 2012 in the Willow/Cedar medication room. The licensee failed to ensure that drugs stored in an area or a medication cart comply with manufacturer's instructions for the storage of the the drugs in regards to the expiration date. [s. 129. (1) (a)]

2. On December 4, 2012, inspector reviewed the expiry dates of stock medications found in the Spruce Grove medication cart. Two opened bottles of Tylenol plain 325mg tablets were expired, one had the expiry date of March 2012 and the other had October 2012. In addition, two bottles of Allernix 50mg were expired in June 2012 and one bottle of Allernix 25mg was expired in May 2012. The Birch Grove medication cart contained an open bottle of Tylenol plain 325mg tablets with an expiry date of October 2012. The licensee did not comply with the manufacturer's instructions regarding expiration dates of these medications. The licensee failed to ensure that drugs are stored in an area or a medication cart that complies with manufacturer's instructions for the storage of the drugs. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring drugs are store in an area that complies with manufacturer's instructions for the storage of the drugs, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. A Ziploc bag containing treatment creams was observed to contain a tube of prescribed gel for resident #88419. According to staff member S#108 this is applied to the resident. The physician's orders were reviewed and a prescription for this treatment cream was not found. A treatment cream was being applied to the resident despite not being prescribed. The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. [s. 131. (1)]

2. Resident #88419 had a physician's order for a cream to be applied for a specific duration. The treatment administration record (TAR) fwas reviewed. During the specified time period that the prescription cream was ordered to be applied, there were several treatment times in which the staff initials were absent from the TAR sheets. In addition, there were several more applications of the treatment cream after the prescription end date. The treatment cream that was ordered for this resident was not administered as directed by the physician. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

3. An interview was conducted with staff member #107 on December 5, 2012 and it was identified that this staff member has not had training in the application of topical medications by a member of the registered nursing staff. The staff member "learned about this in the PSW program". This staff member had not been trained by a member of the registered nursing staff in the administration of topical medication. The licensee failed to ensure that the staff member administering the topical has been trained by a member of the registered nursing staff in the administration of topical medication. [s. 131. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring medications are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #17: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. Inspector reviewed the health care records of seven residents admitted to the home. Five of the seven residents that were reviewed had not been screened for tuberculosis within the required time frame. The licensee failed to ensure that each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. [s. 229. (10) 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 ensuring that all residents admitted to the home are screened for tuberculosis within 14 days of admission, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. On December 4, 2012, the inspector observed resident #00009 seated in a shower chair coming out of the tub room, being pushed down the corridor into their room with their buttocks exposed to the inspector or any other persons in the hallway. The licensee failed to ensure that the residents rights are fully respected and promoted including every residents' right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. [s. 3. (1) 1.]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 10. Recreational and social activities

Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that there is an organized program of recreational and social activities for the home to meet the interests of the residents. 2007, c. 8, s. 10 (1).

Findings/Faits saillants :

1. The activity flow sheets for two months were reviewed by inspector and it was found that resident #88432 only attended activities on seven days. On November 28, 2012 and December 6, 2012, resident #88432, reported to the inspector that the home did not provide enough organized recreational and social activities that are of interest to the resident. The licensee failed to ensure that there is an organized recreational and social activity programs to meet the interests of the residents. [s. 10. (1)]

WN #20: 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. On November 27, 2012 and December 4, 2012, female resident #88383 was observed to have approximately four or five facial hairs on her chin that were in excess of 2 cm. On December 4, 2012 staff member S#112, reported to inspector that female residents will have their facial hair shaved during their bath. The licensee failed to ensure that resident #88383 received individualized personal care, including hygiene care and grooming on a daily basis. [s. 32.]

WN #21: 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. On November 28, 2012, resident #88368 was observed to have an dressing on. On December 5, 2012 it was determined that a "wound assessment tool" for the skin tear had not been initiated at the time of the injury and subsequent application of a dressing. A review of the online progress notes did not include a notation regarding an injury. The registered nursing staff had not conducted an skin assessment using the home's "wound assessment tool" in order to document information about the skin tear. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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. [s. 50. (2) (b) (i)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. Resident #88433 is identified as high nutritional risk. The "food and fluid intake" records for the month of November 2012 were reviewed and the fluid intake for the morning beverage pass and afternoon snack/beverage pass are not consistently recorded. Resident #88433 had an identified risk relating to nutrition and hydration and the system used to monitor the food and fluid intake was not fully implemented. The licensee failed to ensure that the programs include a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration. [s. 68. (2) (d)]

WN #23: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(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. 78 (2)
(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. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)

(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. Inspector reviewed the home's admission package. Inspector noted the packaged contained outdated, inaccurate and incomplete information. Inspector further noted the package was completely lacking some of the requirement elements. The inspector noted the residents' bill of rights and information provided about medication and psychiatric leave was outdated. Inspector noted the package included a list of services provided, however failed to identify the cost for these services. The package did not include: the home's policy to promote zero tolerance of abuse, an explanation of the duty to make mandatory reports, the ministry's Action Line phone number and hours of operation, the home's minimizing of restraining policy, the maximum charges for accommodations, the obligation to pay the basic accommodation charge and information on whistle-blowing protection as afford under s.26 of the Act. The licensee failed to ensure the package of information includes all required information. [s. 78. (2) (a)]

WN #24: 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,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

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 November 30, 2012, the "Sera Lift" labeled #1 on the Cedar Grove was observed to have a large amount of food crumbs and debris on the foot surface, food debris in crevices of the lift and the resident handles of lift were also soiled. As part of the organized program of housekeeping under clause 15(1)(a) of the Act, the licensee failed to ensure that procedures are developed and implemented for the cleaning and disinfection of resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs. [s. 87. (2) (b)]

2. On November 27, 28, 2012 and December 4, 2012, at various times of the day between 09:00h and 15:30h, December 5, 2012, at 10:28h, and December 6 at 18:00h, 2012, room # 402 was found to be malodourous, in that it smelled of dirty laundry or unclean fabric upholstery. The licensee fail to ensure that, 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, addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours. O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. Resident #88368 had a fall which resulted in transfer to hospital. The Long-Term Care Homes Critical Incident System was reviewed for an incident report outlining this particular resident's fall with transfer to hospital and no report was identified. An interview was conducted with staff member S#110, on December 4, 2012 and it was confirmed that a report was not filed with the Ministry for this particular incident. The licensee failed to ensure that the Director is informed, no later than one business day after the occurrence, of an injury in respect of which a person is taken to hospital. [s. 107. (3)]

WN #26: 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. It was determined through interview with staff member S#105, that the ward clerk orders the government stock for the home. An interview was conducted with staff member S#111 and it was confirmed that they obtain the key for the stock cupboard from a registered staff member and then can access the drug supply cupboard in order to restock the cupboard or to place an order. The licensee failed to ensure that steps are taken to ensure access to the medication storage areas shall be restricted to, persons who may dispense, prescribe or administer drugs in the home and the Administrator. [s. 130. 2.]

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. On December 4, 2012, an interview was conducted with staff member S#109 regarding resident #88419's use of a front closing seat belt when up in the wheelchair and the use of all four side rails when in bed. Staff member S#109 told the inspector that they were unaware of the need for consent or a MD order for use of all four side rails for a resident. The staff member confirmed that the resident was able to undo the seat belt and questioned along with the inspector why (PSW) staff were using a "Hourly Monitoring Restraint Form" for the use of the seat belt when it was not considered a restraint. The staff members providing care to this resident did not demonstrate a clear understanding of restraint use. The licensee failed to ensure that staff who apply physical devices or who monitor residents restrained by physical devices are training in the application, use and potential dangers of these physical devices. [s. 221. (1) 5.]

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.O. 2007, c.8 s. 19. (1)	CO #001	2012_104196_0026	188

Issued on this 14th day of March, 2013

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