



**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) :	MONIQUE BERGER (151)
Inspection No. / No de l'inspection :	2011_050151_0004
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Date of Inspection / Date de l'inspection :	Aug 16, 17, 18, 23, 24, 30, Oct 12, 13, Nov 7, 22, 24, 2011; Jan 3, 4, 5, 2012
Licensee / Titulaire de permis :	MANITOUWADGE GENERAL HOSPITAL 1 HEALTH CARE CRESCENT, MANITOUWADGE, ON, P0T-2C0
LTC Home / Foyer de SLD :	MANITOUWADGE GENERAL HOSPITAL 1 HEALTH CARE CRESCENT, MANITOUWADGE, ON, P0T-2C0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JUDITH C. HARRIS

To MANITOUWADGE GENERAL HOSPITAL, you are hereby required to comply with the following order(s) by the date (s) set out below:



**Ministry of Health and
Long-Term Care**

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

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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 :

O.Reg 79/10, s. 65. Recreational and social activities program

Order / Ordre :

The licensee shall prepare and submit a plan for achieving compliance with O. Reg. 79/10, s. 65 (1) (2): to ensure that the home has an organized recreational and social activities program that addresses all the stipulations listed s 65 (2). In particular, the plan shall address how it will ensure that the program is organized in type and frequency to benefit all residents of the home and to reflect their interests. The plan should also include plans to provide programming on week-ends and in the evenings.

Grounds / Motifs :

1. The program does not include the development and implementation of a schedule of recreation and social activities that are offered during days, evenings and weekends.[O.Reg.79/10, s.65. (2) (b)]

Activation calendars reviewed for the months of August, July and June 2011 show that there are no planned activities for evenings or week-ends. Residents interviewed confirm that there are no activities on week-ends and in the evenings.

Staff interviewed confirm that there are no activities scheduled for residents on week-ends or in the evenings

2.***** The recreational and social activities program does not include services for residents with cognitive impairments and residents who are unable to leave their room. Recreation and social activities are not of a frequency and type to benefit all residents of the home and reflect their interests.
[O.Reg. 79/10,s.65 (2) (c)].

Inspector reviewed the health care record of a resident who is cognitively and physically impaired. The recreation/socialization care plan for this resident does not meet the resident's unique needs.

Review of the residents attendance at activities for the month of July 2011 shows that a cognitively and physically impaired resident had a total of 35 minutes or 3 activities for the month. In comparison, residents who were independent and able to bring themselves to the therapy department for the planned programs received on averages 522 minutes of activation and on average 28 activities for this same month.

In an interview, staff involved with recreational and socialization programming identified the following:

- the Occupational/Physiotherapy Assistant (OPA) is the one responsible for making up the activation calendar for the ELDCAP unit.
- there are no formal dedicated hours to do programming with the residents.
- one-on-one with the residents is done when the Physio/OT department of the hospital is not busy. Staff interviewed stated this is infrequent and that one-on-one activation consists mainly of friendly visiting.
- residents are not transported to the physiotherapy department for activities, they come on their own,
- activities through PACE[People Advocating for Change through Empowerment] are open to residents from the ELDCAP unit, but residents must come on their own. (151)



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section 154 of the *Long-Term Care
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**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

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le :

Feb 08, 2013

MB.



**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
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REVIEW/APEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the

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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.



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Ordre(s) de l'inspecteur
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RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
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 5th day of January, 2012

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

Name of Inspector /
Nom de l'inspecteur : MONIQUE BERGER

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



**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
prévus le Loi de 2007 les
foyers de soins de longue**

**Health System Accountability and Performance
Division
Performance Improvement and Compliance Branch**
**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la performance et de la
conformité**

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

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

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 16, 17, 18, 23, 24, 30, Oct 12, 13, Nov 7, 22, 24, 2011; Jan 3, 4, 5, 2012	2011_050151_0004	Resident Quality Inspection

Licensee/Titulaire de permis

MANITOUWADGE GENERAL HOSPITAL
1 HEALTH CARE CRESCENT, MANITOUWADGE, ON, P0T-2C0

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

MANITOUWADGE GENERAL HOSPITAL
1 HEALTH CARE CRESCENT, MANITOUWADGE, ON, P0T-2C0

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

MONIQUE BERGER (151)

Inspection Summary/Résumé de l'inspection

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

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

- Administrator
- Director of Care
- Nurse Manager
- Registered Staff
- RAI/MDS Coordinator
- Rehabilitation Assistant
- Community Outreach worker
- Food Service Supervisor
- Accounts Receivable Clerk
- Lead for Maintenance Program
- Lead for Housekeeping program
- Residents
- Families/visitors

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

- Direct observations of the delivery of care and services to residents.
- Daily walk-through of the home
- Observed dining and meal delivery service,
- Reviewed policies and procedures manuals,
- Reviewed resident health care records,
- Directly observed medication administration to residents,
- Reviewed the home's programs relating to restorative care, pain management, fall management, skin and wound care, continence care and bowel management and responsive behavior management,
- Reviewed Activation Program goals, objectives, calendar of activities,
- Reviewed activation attendance records,
- Reviewed admission information given to new residents
- Reviewed required posting of information,

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	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 O.Reg 79/10, s. 65. Recreational and social activities program

Findings/Faits saillants :

1. ****The program does not include the development and implementation of a schedule of recreation and social activities that are offered during days, evenings and weekends.[O.Reg.79/10, s.65. (2) (b)]

Activation calendars reviewed for the months of August, July and June 2011 show that there are no planned activities for evenings or week-ends. Residents interviewed confirm that there are no activities on week-ends and in the evenings.

Staff interviewed confirm that there are no activities scheduled for residents on week-ends or in the evenings

2.**** The recreational and social activities program does not include services for residents with cognitive impairments and residents who are unable to leave their room. Recreation and social activities are not of a frequency and type to benefit all residents of the home and reflect their interests.
[O.Reg. 79/10,s.65 (2) (c)].

Inspector reviewed the health care record of a resident who is cognitively and physically impaired. The recreation/socialization care plan for this resident does not meet the resident's unique needs.

Review of the residents attendance at activities for the month of July 2011 shows that a cognitively and physically impaired resident had a total of 35 minutes or 3 activities for the month. In comparison, residents who were independent and able to bring themselves to the therapy department for the planned programs received on averages 522 minutes of activation and on average 28 activities for this same month.

In an interview, staff identified the following:

- the Occupational/Physiotherapy Assistant (OPA) is the one responsible for making up the activation calendar for the ELDCAP unit.
- there are no formal dedicated hours to do programming with the residents.
- one-on-one with the residents is done when the Physio/OT department of the hospital is not busy. Staff interviewed stated this is infrequent and that one-one activation consists mainly of friendly visiting.
- residents are not transported to the physiotherapy department for activities, they come on their own,
- activities through PACE[People Advocating for Change through Empowerment]are open to residents from the ELDCAP unit, but residents must come on their own.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

- 1. Communication of the seven-day and daily menus to residents.**
- 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.**
- 3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.**
- 4. Monitoring of all residents during meals.**
- 5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.**
- 6. Food and fluids being served at a temperature that is both safe and palatable to the residents.**
- 7. Sufficient time for every resident to eat at his or her own pace.**
- 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.**
- 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.**
- 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.**
- 11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).**

s. 73. (2) The licensee shall ensure that,

(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and

(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. *****Residents who require assistance with eating or drinking are not served a meal only when someone is available to provide the assistance [O.Reg.79/10, s.73. (2) (b)]

Inspector made the following observations during attendance at the home August 16,17,18,23,24,25,2011. All residents receive their entire meal on a tray (tray services) at the same time for all meals, regardless of the type of assistance that is required for the individual residents. Staff were observed to attend to set up the residents in the dining room first, then proceed to go down the hallway, systematically going into each room to assist with any set up (i.e opening of packages, etc) and ending with providing full assistance to those residents requiring. This process took on average 10-15 minutes.

2. *****The meals are not served course by course unless otherwise indicated by the resident or the residents' assessed needs. [O.Reg.79/10, s. 73. (1) 8]

Inspector was in attendance in the home August 16,17,18,23,24,25,2011. Inspector directly observed that all residents received tray service for all meals. Staff interviewed confirmed that all residents received tray service in ELDCAP.

3. *****The meal service is not provided in a congregate dining setting unless a resident's assessed needs indicate otherwise [O.Reg.79/10, s. 73. (1) 3]

During Inspector's attendance at the home (August 16, 17, 18, 23,24,25, 2011) the following dining pattern was observed:

**Breakfast: all residents were served breakfast on trays and in their rooms

**Lunch: all residents received tray service, on average 4-5 residents presented themselves to the dining room for congregated dining, the rest (4-5) ate in their rooms,

**Supper: on average 3-4 residents ate in the dining room, all other residents ate in their rooms

At no time did the multi-purpose activity/dining room have preparation in anticipation of a meal: i.e. table decoration, place settings, condiments put out. Residents who presented themselves to the dining room seated themselves and waited until staff placed the entire meal on a tray in front of them.

4. *****The daily and weekly menus are not communicated to residents [O.Reg.79/10, s. 73. (1) 1]

Alternate choices for daily and weekly menus are not posted on either the daily white board or the weekly printed and posted sheets.

At no time during Inspector attendance in the home did the Inspector observe staff communicate the alternate choice for the meal or to poll residents as to their choice of entree.

Staff interviewed confirmed that the residents are not asked as to their choice in regards to the alternate entree for each meal.

5. *****The licensee has not ensured that the dining and snack service includes a review of the the meal and snack times by the Residents' Council [O.Reg.79/10, s. 73. (1) 2.]

Review of the minutes of the last 3 council meetings does not include discussion regarding meal and snack times. In an interview, a resident stated there was no recollection of this ever being discussed at any meeting of the Resident's Council.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the development of a food service program that meets the needs of the residents and reflects the requirements of O.Reg.79/10, s.73., to be implemented voluntarily.

WN #3: 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 subsections:

s. 110. (6) Every licensee shall ensure that no physical device is applied under section 31 of the Act to restrain a resident who is in bed, except

(a) to allow for a clinical intervention that requires the resident's body or a part of the resident's body to be stationary; or

(b) if the physical device is a bed rail used in accordance with section 15. O. Reg. 79/10, s. 110 (6).

Findings/Faits saillants :

1. The licensee has not ensured that no physical device is applied under section 31 of the Act to restrain a resident who is in bed, except to allow for a clinical intervention that requires the resident's body or a part of the resident's body to be stationary.[O.Reg.79/10, s. 110. (6)]

August 24, 2011 at 1500 h. Inspector interviewed home staff who confirmed that a resident had a restraining device when in bed. Staff confirmed the bed restraint was in the care plan, and that the necessary consents and physician order had been obtained.

Inspector reviewed the resident's plan of care care plan. The plan identifies the resident's risk of falls and requirement for restraints. The Kardex directs staff to apply both chair and bed restraints and, in addition to the restraining device, to use both side rails at all times when the resident is in bed.

Review of the resident's health care record shows that the Doctor's order is for a restraining device. Staff interviewed confirmed that this restraint was intended for the resident when in bed.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance in the development and implementation of policies and procedures that ensure no resident who is in bed is restrained by a physical device, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.

3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. *****The licensee has not ensured that for each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, that a written record relating to each evaluation includes:

- * the date
 - * the names of the persons who participated
 - * a summary of the changes made, and
 - * the date that the changes were implemented
- [O.Reg.79/10, s. 30. (1) 4.]

Staff interviewed confirmed that though all programs are reviewed annually, there is no record kept as to:

- * the date
- * the names of the persons who participated
- * a summary of the changes made, and
- * the date that the changes were implemented

2. *****The licensee does not ensure that for each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, that there is a written description of the program that includes:

- * goals and objectives
 - * relevant policies, procedures, protocols
 - * provision of methods to reduce risk
 - * methods to monitor outcomes, and
 - * protocols for referral of resident to specialized resources where required
- [O.Reg.79/10, s.30.(101)]

Inspector reviewed the home's manuals: "Administration" and "Long Term Care Manual". In addition, Staff interviewed confirmed that there were no other source for the inspector to reference in regards to program information and their related policies or procedures. Inspector made the following observations:

* **RESTORATIVE CARE**; only one policy (B-262) exists to describe the program. The program goal is present, however there is no other references in regards to:

- other relevant policies and procedures
- provisions to reduce risks
- methods to monitor outcomes
- Protocols for referral to monitor outcomes.

* **RECREATION AND SOCIAL ACTIVITIES**: only one policy is found - Policy reference B-252. Goals and objectives are found. The policy then goes on to reference qualifications for worker and what their duties consist of. There is no other references. The following was found to be lacking:

- a.) information for individual assessment of needs in regards to Recreation and Activation,
- b.) information for the on-going monitoring and assessment of the effectiveness of individual programming,
- c.) methods/protocols to provide for both group and 1;1 activities.
- d.) identification of any risk to any activities.

* **RELIGIOUS AND SPIRITUAL SERVICES**: Policy B-253 is brief and serves only to describe the goals and objectives of the program. There is no other references in regards to:

- other relevant policies and procedures
- provisions to reduce risks
- methods to monitor outcomes
- Protocols for referral to monitor outcomes.

* **FOOD SERVICES: NUTRITION AND HYDRATION**: only one policy was found: reference B-145 "New Resident Admission". No other policies were found in the LTC Manual or Administration Binder. Inspector 151 interviewed Fatima Dubreuil August 25, 2011 at 0800 h. Dubreuil confirms that the last revision to the Food Service Manual was in 2005 and

that the existing policies are more protocols in reference to staff duties and responsibilities

Inspector 151 interviewed Louise Baran, Nurse Manager on August 25, 2011 at 1100 h. After reviewing the legislation, Louise confirmed the home's policies did not meet the new regulations requirements.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance in providing the requirements for organized programs listed in the regulation for the restorative care, food service, recreation/social activities and religious/spiritual programs, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:

- 1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.**
- 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.**
- 3. Resident monitoring and internal reporting protocols.**
- 4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).**

s. 53. (3) The licensee shall ensure that,

- (a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;**
- (b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and**
- (c) a written record is kept relating to each evaluation under clause (b) 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. 53 (3).**

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

- (a) the behavioural triggers for the resident are identified, where possible;**
- (b) strategies are developed and implemented to respond to these behaviours, where possible; and**
- (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

Findings/Faits saillants :

1. *****The actions taken to meet the needs of the resident with responsive behaviours do not include:

- * assessment
- * reassessments
- * interventions, and
- * documentation of the resident's responses to the interventions

[O.Reg.79/10, s. 53. (4) (c)]

Two staff interviewed confirmed that the home does not have a formal program that describes care approaches, screening protocols, assessment and re-assessment and identification of triggers for resident who exhibit responsive behaviors.

Staff interviewed confirmed that the home did have residents who exhibited responsive behaviours. Inspector observed that there are no program protocols developed to provide for the assessments, re-assessments, interventions and documentation of this resident's responses to interventions for his identified responsive behaviours.

Inspector reviewed the home's policy manuals and found only one policy addressing responsive behaviors:RESPONSIVE BEHAVIORS: B-260. last review date June 2010. The policy is generic in nature and does not address screening protocols, assessment, re-assessment or the identification of behavioral triggers that result in responsive behaviors.

2. *****There are no written approaches to care developed to meet the needs of the residents with responsive behaviours that include:

- * screening protocols
- * assessment
- * reassessment, and
- * identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other [O.Reg.79/10, s. 53. (1) 1.]

Staff interviewed confirm that the home does not have a formal program that describes care approaches, screening protocols, assessment and re-assessment and identification of triggers for resident who exhibit responsive behaviors.

Inspector Review of the home's policy manuals found only one policy addressing responsive behaviors:RESPONSIVE BEHAVIORS: B-260. last review date June 2010. The policy is generic in nature and does not address screening protocols, assessment, re-assessment or the identification of behavioral triggers that result in responsive behaviors.

3. *****The responsive behaviour program is not developed and implemented in accordance with evidence-based practices or, if there are none, prevailing practices [O.Reg.79/10, s.53. (3) (a)]

staff interviewed confirm that the home does not have a formal program that describes care approaches, screening protocols, assessment and re-assessment and identification of triggers for resident who exhibit responsive behaviors.

Staff interviewed confirmed that there were residents on the unit who exhibited responsive behaviours.

Inspector reviewed the home's policy manuals and found only one policy addressing responsive behaviors:RESPONSIVE BEHAVIORS: B-260. last review date June 2010. The policy is generic in nature and does not address screening protocols, assessment, re-assessment or the identification of behavioral triggers that result in responsive behaviors.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the development of programming that meets the needs of residents with responsive behaviors, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following subsections:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii. equipped with a door access control system that is kept on at all times, and

iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9. (1).

Findings/Faits saillants :

1. ***The licensee has not ensured that all doors leading to the outside of the home are kept closed and locked.**

[O.Reg.79/10, s.9.(1)i]

Inspector toured the unit August 16, 2011 at 0930 h. and noted that the home has 2 doors that lead to the outside.

Neither of these doors are locked, and neither of these outside areas are secure for residents. Once through the unlocked doors, any and all residents, including those who have cognitive impairments, have unprotected access to a wooded area and a lake (approximately 500 ft from the home).

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 that all doors leading to the outside of the home are kept closed and locked, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following subsections:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:

1. The resident's ability under subsection 82 (2) of this Regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1).
2. The resident's obligation to pay the basic accommodation charge as described in subsection 91 (3) of the Act.
3. The obligation of the resident to pay accommodation charges during a medical, psychiatric, vacation or casual absence as set out in section 258 of this Regulation.
4. The method to apply to the Director for a reduction in the charge for basic accommodation and the supporting documentation that may be required, including the resident's Notice of Assessment issued under the Income Tax Act (Canada) for the resident's most recent taxation year.
5. A list of the charges that a licensee is prohibited from charging a resident under subsection 91 (1) of the Act.
6. The list of goods and services permitted under paragraph 3 of subsection 91 (1) of the Act that a resident may purchase from the licensee and the charges for those goods and services.
7. The resident's ability to have money deposited in a trust account under section 241 of this Regulation.
8. The Ministry's toll-free telephone number for making complaints about homes and its hours of service. O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. *****On Aug. 23, 2011, Inspector 151 reviewed the home's Admission Package: MANITOUWADGE GENERAL HOSPITAL LONG TERM CARE FACILITY: RESIDENT INFORMATION BOOKLET. The admission package does not include information on the ability to retain a physician or RN (EC) to perform the required services [O.Reg.79/10, s. 224. (1) 1]
2. *****On Aug. 23, 2011, Inspector 151 reviewed the home's Admission Package: MANITOUWADGE GENERAL HOSPITAL LONG TERM CARE FACILITY: RESIDENT INFORMATION BOOKLET. The admission package does not include the resident's obligation to pay accommodation charges during a medical, psychiatric, vacation or casual absence from the home [O.Reg.79/10, s. 224. (1) 3]
3. *****On Aug. 23, 2011, Inspector 151 reviewed the home's Admission Package: MANITOUWADGE GENERAL HOSPITAL LONG TERM CARE FACILITY: RESIDENT INFORMATION BOOKLET. The admission package does not include how to apply for a reduction in the charge for basic accommodation, and the supporting documentation required, e.g. the most recent Notice of Assessment issued under the Income Tax Act [O.Reg.79/10, s.224. (1) 4.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:

1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
 - i. the matters referred to in paragraph 3,
 - ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
 - iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. *****In regards to continuous quality assurance, the home does not maintain a record of:

- * the names of the persons who participated in evaluations, and
- * the dates improvements were implemented [O.Reg.79/10, s. 228. 4. ii.]

In an interview with Director of Care stated that the improvements/initiatives are documented but the names of the persons who participated in this is not being done.

2. *****The licensee does not ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents are communicated to the Residents' Council [O.Reg.79/10, s. 228. 3.]

Inspector interviewed resident who stated that, other than the open invitation for the public to attend hospital board meetings, there has been no other opportunity provided for communication with Resident Council regarding the quality of accommodation, care, services, programs and goods provided to residents.

Inspector reviewed the Resident/Family Council minutes for May, June, July 2011. There is no mention in regards to the quality of accommodation, care, services, programs and goods provided to residents.

**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program
Specifically failed to comply with the following subsections:**

s. 229. (2) The licensee shall ensure,

- (a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;**
- (b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;**
- (c) that the local medical officer of health is invited to the meetings;**
- (d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and**
- (e) that a written record is kept relating to each evaluation under clause (d) 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. 229 (2).**

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:

- 1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.**
- 2. Residents must be offered immunization against influenza at the appropriate time each year.**
- 3. Residents must be offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.**
- 4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.**
- 5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).**

Findings/Faits saillants :

1. *****Residents are not offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website [O.Reg.79/10, s. 229. (10) 3.]

Staff interviewed confirmed that the home has not as yet begun the process to offer tetanus and diphtheria immunization.

2. ***** Staff interviewed confirmed that the home is not ensuring that written record of the annual Infection Prevention and Control program evaluation kept includes the following:

- * the date of the evaluation
 - * the names of the persons who participated
 - * a summary of the changes made, and
 - * the date those changes were implemented
- [O.Reg.79/10, s. 110. (6)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges

The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:

1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,

i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and

ii. the Minister under section 90 of the Act.

2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario.

3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network.

4. Charges for goods and services provided without the resident's consent.

5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home.

6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program.

7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account.

8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. *****The licensee has not ensured that residents are not charged for anything the licensee must ensure is provided to a resident under the Regulation, unless a charge is expressly permitted.

[O.Reg.79/10, s. 245. 8]

Inspector reviewed the document forwarded to the resident's upon admission that itemizes Uninsured Services and notes that it does not have the cost associated with each of these services, and does not provide for the resident to sign the document in acknowledgment that the resident/SDM wishes these services and agrees with the associated cost.

Interview with staff confirmed that staff do not get residents to sign the form "Uninsured Services". In regards to these, residents are billed without them knowing prior what the services will cost them.

2. *****The licensee has not ensured that residents are not charged for goods and services provided without the resident's consent.

[O.Reg.79/10, s.245. 4.]

Inspector reviewed the document forwarded to the resident's upon admission that itemizes Uninsured Services and notes that it does not have the cost associated with each of these services, and does not provide for the resident to sign the document in acknowledgment that the resident/SDM wishes these services and agrees with the associated cost. In an interview, staff confirmed that staff do not get residents to sign the form "Uninsured Services". In regards to these, residents are billed without them knowing prior what the services will cost them.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following subsections:

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

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

Findings/Faits saillants :

1. *****The plan of care is not based on an interdisciplinary assessment of the resident's psychological well-being [O.Reg.79/10, s. 26. (3) 6]

Inspector reviewed the health care records for a resident . No formal admission assessment of the resident's recreational and social activities was found.

Review of a cognitively and physically impaired resident's plan of care regarding socialization and recreation shows that the home places the onus on family to provide for this need.

2. *****The care plan is not based on interdisciplinary assessment of the resident's special needs and treatments [O.Reg.79/10, s. 26. (3) 18].

In an interview, a resident declared daily pain in the legs and back. Progress notes in the resident's health care record indicate the resident receives analgesia on a frequent basis. The most recent Care Plan/RAPS for the resident has no care plan for the management of his pain. It is concluded that since there is no plan of care in relation to pain management, the resident did not receive inter-disciplinary assessment of this need.

3. *****The plan of care is not based on an interdisciplinary assessment of the resident's activity patterns and pursuits. [O.Reg.79/10, s. 26. (3) 16]

Inspector 151 reviewed the health care records for a resident . No formal admission assessment of the resident's recreational and social activities was found.

Inspector reviewed the health care record for a resident who was cognitively and physically impaired. In regards to socialization and recreation, the plan of care is not reflective of the unique activity patterns or pursuits of this resident.

WN #12: 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 subsections:

s. 78. (2) The package of information shall include, at a minimum,

- (a) the Residents' Bill of Rights;**
- (b) the long-term care home's mission statement;**
- (c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;**
- (d) an explanation of the duty under section 24 to make mandatory reports;**
- (e) the long-term care home's procedure for initiating complaints to the licensee;**
- (f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints;**
- (g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained;**
- (h) the name and telephone number of the licensee;**
- (i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home;**
- (j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home;**
- (k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges;**
- (l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge;**
- (m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs;**
- (n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents;**
- (o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package;**
- (p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations;**
- (q) an explanation of the protections afforded by section 26; and**
- (r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)**

Findings/Faits saillants :

1. *****Inspector 151 reviewed the Admission Package: MANITOUWADGE GENERAL HOSPITAL LONG TERM CARE FACILITY: RESIDENT INFORMATION BOOKLET. The admission package does not include an explanation of whistle-blowing protections related to retaliation. [LTCA,2007 S.O.2007,c.8, s.78. (2) (q)]

2. *****Inspector 151 reviewed the Admission Package: MANITOUWADGE GENERAL HOSPITAL LONG TERM CARE FACILITY: RESIDENT INFORMATION BOOKLET. The admission package does not include a disclosure of any non-arm's length relationships that exist between the licensee and other providers who offer care, services, programs or goods to residents [LTCA,2007 S.O.2007,c.8, s. 78. (2) (n)]

3. *****Inspector 151 reviewed the Admission Package: MANITOUWADGE GENERAL HOSPITAL LONG TERM CARE FACILITY: RESIDENT INFORMATION BOOKLET. The admission package does not include 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, with respect to the supply of drugs[LTCA,2007 S.O.2007,c.8, s.78. (2) (m)]

4. *****Inspector 151 reviewed the Admission Package: MANITOUWADGE GENERAL HOSPITAL LONG TERM CARE FACILITY: RESIDENT INFORMATION BOOKLET. The admission package does not include the home's policy on minimizing the restraining of residents and how to obtain a copy of the policy.[LTCA,2007 S.O.2007,c.8, s.78. (2) (g)]

5. *****Inspector 151 reviewed the Admission Package: MANITOUWADGE GENERAL HOSPITAL LONG TERM CARE FACILITY: RESIDENT INFORMATION BOOKLET. The admission package does not include an explanation of the duty to make mandatory reports related to incidents resulting in harm or risk of harm to a resident, such as:

- * improper or incompetent treatment or care of a resident
- * abuse by anyone or neglect by the licensee or staff
- * unlawful conduct
- * misuse or misappropriation of a resident's money
- * misuse or misappropriation of funding provided to the licensee

[LTCA,2007 S.O.2007,c.8, s.78. (2) (d)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following subsections:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,

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

Findings/Faits saillants :

1. *****An explanation of whistle-blowing protections related to retaliation was not found posted during inspector walk-through of the home August 17, 2011 and August 23, 2011.[LTCA,2007 S.O.2007,c.8, s.79. (3) (p)]
2. *****The most recent minutes of the Resident's Council meeting was not found posted during inspector walk-through of the home August 17, 2011 and August 23, 2011.[LTCA,2007 S.O.2007,c.8, s.79. (3) (n)]
3. *****An explanation of evacuation procedures was not found posted during inspector walk-through of the home August 17, 2011 and August 23, 2011.
[LTCA,2007 S.O.2007,c.8, s.79. (3) (j)]
4. *****An explanation of the measures to be taken in case of a fire is not found posted during inspector walk-through of the home August 17, 2011 and August 23, 2011.[LTCA,2007 S.O.2007,c.8, s. 79. (3) (i)]
5. *****The policy to minimize the restraining of residents as well as information about how a copy of the policy can be obtained was not found posted during walk-through of the home August 17, 2011 and August 23, 2011.[LTCA,2007 S.O.2007,c.8, s.79. (3) (g)]
6. *****The policy to promote zero tolerance of abuse and neglect of residents was not found during walk-through of the home August 17, 2011 and August 23, 2011.[LTCA,2007 S.O.2007,c.8, s.79. (3) (c)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following subsections:

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

s. 85. (4) The licensee shall ensure that,

(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3);

(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any;

(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and

(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. *****The home does not seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results [LTCA,2007 S.O.2007,c.8, s.85. (3)]

In an interview staff confirmed the Resident/Family Council has not been consulted in the development of the satisfaction questionnaire.

2. *****The licensee does not document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.[LTCA,2007 S.O.2007,c.8, s.85. (4) (a)]

Resident interviewed stated the council has never seen the results of the satisfaction questionnaire, nor has the licensee sought any advice in regarding to survey findings.

Review of the council minutes for May, June, July 2011 shows no mention regarding Satisfaction Surveys.

3. The licensee does not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.[LTCA,2007 S.O.2007,c.8, s.85.(3)]

A resident interviewed stated that the council was ever asked for their input into the development of the Satisfaction Questionnaire,

Review of the minutes for the months of May, June, July 2011 shows that there is no mention of satisfaction questionnaires.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,

(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and

(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. ****The licensee of the home is not ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is:

- (a) in compliance with and is implemented in accordance with all applicable requirements under the Act, and
- (b) complied with [O.Reg.79/10, s.8.(1)]

In reference to restraints, the home has two (2) written policies:

* Nursing: BED SIDE RAILS: B-50: this policy is explicit in identifying that 4 x 1/2 bed rails or both full rails up is considered to be a restraint.

* Nursing: RESTRAINTS: B-265: this policy speaks to the assessment, consent and monitoring requirements when a resident restraint is implemented.

A resident is identified in the plan of care as requiring 4 bed rails up when in bed. This limits movement and according to Policy B-50, this is a restraint. Review of the resident's health care record shows that Policy B-265 stipulations in consideration of a resident who is restrained were not being followed: i.e. no consent for the restraint was found, no record of hourly monitoring and documentation when the restraint is in use was found, and, no record of initial and regular re-assessments that the restraint is still required were found.

Staff interviewed gave conflicting information in regards to how they apply the restraint policy in relation to bed rail use and admitted that they are inconsistent in relation to application of the home's policy: Policy B-265.

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

- (a) a goal in the plan is met;**
- (b) the resident's care needs change or care set out in the plan is no longer necessary; or**
- (c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

Findings/Faits saillants :

1. ****The resident was not 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 [LTCA, 2007 S.O. 2007, c.8, s.6. (10) (b)]

A resident was transferred to an acute care hospital and returned with four (4) new health care issues.

Inspector reviewed the resident's health care record and found that no RAI/MDS assessment for significant change was done upon the resident's return from hospital. Staff interviewed confirmed that no significant change assessment was done upon resident's return from hospital. The home resumed care referencing the original plan of care.

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 56. Residents' Council

Specifically failed to comply with the following subsections:

s. 56. (1) Every licensee of a long-term care home shall ensure that a Residents' Council is established in the home. 2007, c. 8, s. 56 (1).

s. 56. (2) Only residents of the long-term care home may be a member of the Residents' Council. 2007, c. 8, s. 56 (2)

Findings/Faits saillants :

1. *****The licensee is not ensuring that only residents of long-term home are members of the Resident's Council.

[LTCA,2007 S.O.2007,c.8, s.56. (2)]

Inspector 151 observed through resident and staff interviews, and review of Council minutes that the Resident's Council has representation from both the residents and their families. The name of the Council has been changed in this home to "Resident/Family Council".

2. ***** A Resident's Council is not established in the home according to the stipulations of the Act.[LTCA,2007 S.O.2007,c.8, s.56. (1)] in that resident's do not have their own council.

The Resident Council is blended with Family Council. Both residents and family members attend these meetings

Issued on this 6th day of January, 2012

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

Monique G. Berger. (Inspector 151)