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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 8, 2018	2018_536537_0003	000543-18	Resident Quality Inspection

Licensee/Titulaire de permis

The Corporation of the County of Essex
360 Fairview Ave West ESSEX ON N8M 1Y6

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

Sun Parlor Home for Senior Citizens
175 Talbot Street East LEAMINGTON ON N8H 1L9

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

NANCY SINCLAIR (537), ALICIA MARLATT (590), ANDREA DIMENNA (669), CAROLEE MILLINER (144)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 15, 16, 17, 18, 19, 22, 23, 24, 25 and 26, 2018

The following follow up to Orders of the Inspector was completed during this Resident Quality Inspection (RQI):
Log #020729-17 Follow up to order #001 from RQI inspection #2017_566669_005 related to protecting residents from abuse and neglect.

The following intakes were completed concurrently within the RQI:

Related to the management of responsive behaviours, infection control practices and allegation of abuse of a resident.
Log #029380-17/IL-54687-LO/IL-54753-LO

Related to the Allegations of Staff to Resident Abuse:
Log #000025-18/IL-54776-LO
Log #008151-17/CIS M579-000021-17
Log #004003-17/CIS M579-000009-17
Log #021648-17/CIS M579-000046-17

Related to the Allegations of Resident to Resident Abuse:
Log #025651-17/CIS M579-000055-17
Log #011039-17CIS M579-000027-17
Log #017481-17/CIS M579-000035-17
Log #010017-17/CIS M579-000026-17
Log #007297-17/CIS M579-000018-17
Log #013753-17/CIS M579-000030-17

Related to Injury that Results in Transfer to Hospital and which results in a Significant Change in Status:
Log #011385-17/CIS M579-000028-17
Log #010107-17/CIS M579-000025-17
Log #006163-17/CIS M579-000014-17
Log #025287-17/CIS M579-000054-17
Log #024560-17/CIS M579-000050-17
Log #019479-17/CIS M579-000037-17

Related to Improper/Incompetent Care of a Resident related to transfers and positioning:
Log #023662-17/CIS M579-000049-17
Log #024922-17/CIS M579-000056-17

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Manager of

Resident Services and Clinical Practice (MRSCP), Manager Food and Nutrition Services (MFNS), Manager Life Enrichment, Maintenance Supervisor, Administration Assistant, two Registered Dietitians (RD), one Food Service Worker, three Housekeeping Aides (HA), one Volunteer, six Registered Practical Nurses (RN), ten Registered Practical Nurses (RPN), 28 Personal Support Workers (PSW), Residents' Council representative, Family Council representative, residents and family members.

The inspector(s) also conducted a tour of all resident areas and common areas, observed meal service, medication passes, medication storage areas, residents and care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, minutes from meetings and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

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	2017_566669_0005	669

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a written complaint was received concerning the care of a resident it was immediately forwarded to the Director.

A Critical Incident System (CIS) report was submitted by the home following receipt of a written complaint to the Administrator from a family member outlining care concerns about an identified resident.

Administrator told the inspector that the written letter of complaint was reviewed but was not forwarded to the Director immediately upon receipt of the complaint.

The licensee has failed to forward a written letter of complaint concerning the care of a resident to the Director. [s. 22. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director, to be implemented voluntarily.

WN #2: 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. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A Critical Incident System (CIS) report was submitted by the home following receipt of a written complaint to the Administrator from a family member outlining care concerns about an identified resident, including an area of altered skin integrity.

The home's policy titled "Skin and Wound Care Management - 0104-03-00" last revised March 15, 2017, included a directive for registered staff employed by the home to complete a Braden Risk Assessment, Head to Toe Assessment and Skin and Wound Care Checklist as required in response to skin and wound conditions causing skin breakdown.

Review of the clinical record for the resident revealed that assessments were not completed by a member of the registered nursing staff in response to the identified area of altered skin integrity as outlined in the written letter of complaint submitted by the family.

The resident's clinical record included an unsigned and undated assessment of the resident's area of altered skin integrity, completed by an Enterostomal (ET) Therapy Nurse, and a treatment plan initiated.

Director Of Nursing (DON) told the Inspector that the previous DON investigated the written concerns from the family of the identified resident and that registered staff did not complete an assessment in response to the documented complaint related to the resident's skin integrity.

DON advised that although the ET Therapy Nurse was an employee of the home and had completed an assessment that DON would expect assessments to be completed by a member of the registered nursing staff immediately after the concern was reported.

Administrator said they had notified the previous DON of the written letter of complaint related to impaired skin integrity for follow up.

The licensee has failed to ensure the resident received a skin assessment by a member of the registered nursing staff when the resident presented with impaired skin integrity. [s. 50. (2) (b) (i)]

Additional Required Actions:

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

WN #3: 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. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated: A change of 5 per cent of body weight, or more, over one month; a change of 7.5 per cent of body weight, or more, over three months; a change of 10 per cent of body weight, or more, over 6 months; any other weight change that compromised the resident's health status.

During the home's Resident Quality Inspection (RQI), it was identified during the staff interview that a resident had been assessed as having a significant weight change and that no actions were taken to address the weight change.

The home's policy titled "Weight - Nursing 0104-21, Dietary 0404-06-25" last revised October 23, 2015, stated that weight loss was an indicator that the resident's nutritional needs were not being met, and that residents' weights assisted the Registered Dietitian (RD) in determining the nutritional risk level and whether to implement nutritional interventions. The policy continued that Personal Support Workers (PSW) ensured monthly weights were completed, and that each resident with a difference of two kilograms (kg) was to be re-weighed. The policy also said that the RD's responsibility was to ensure that residents with the following weight changes were assessed and actions were taken and outcomes were evaluated: 5 per cent of body weight, or more, over one month; 7.5 per cent of body weight, or more, over three months; 10 per cent of body weight, or more, over six months.

The resident's clinical record was reviewed and identified the weight change,a risk level and goals.

The Minimum Data Set (MDS) Quarterly review was reviewed and did not indicate that interventions were in place to address the weight change.

An email sent by a food service supervisor was reviewed and stated that any weight changes of 2 kg must be reweighed, and included that the identified resident had not yet been reweighed.

The care plan was reviewed and did not include any interventions to address the significant weight change.

The electronic Physician’s Orders were reviewed and included a diet order, but did not contain any resolved, cancelled or struck-out orders for interventions addressing the resident’s significant weight change.

A Personal Support Worker (PSW) and a Registered Practical Nurse (RPN) were interviewed and stated that the resident looked like they had a significant weight change. RPN was unsure if the resident was on any interventions.

Manager of Food and Nutrition Services (MFNS) was interviewed and explained that the home had two RDs who were responsible for assessing residents and putting interventions in place for weight changes. MFNS explained that PSWs weighed residents monthly, and a list of residents who showed a difference of 2 kg or more was sent out by a food service supervisor to notify the units which residents required reweighs. MFNS stated that when the RD addressed weight changes, they should be documented in a progress note. MFNS said that if there was no significant weight change on the reweigh, the RD would not do anything because the updated weight report would no longer reflect a significant change.

The RD was interviewed and explained that weights were triggered in PCC for significant changes, and the RD stated that they addressed and documented weight changes in the progress notes. RD said that a food service supervisor sent reminders to staff for reweighs for any change of 2 kg or greater in one month. RD shared that the RDs would document in the initial weight change progress note that a reweigh was pending, and if the weight change was still significant based on the reweigh, another weight exception alert would trigger and the RD would address and document in a weight change progress

note; if the reweigh was not significant, the RD would not address or document it. RD said that implementing interventions for a resident with a significant weight change would depend on interventions that had been offered to the resident in the past, and they would look for documentation of previous interventions in the progress notes and the care plan. RD added that interventions for weight gain change depended on the wishes of the resident and their family, and it would be documented in the RAPS or in a progress note. RD stated that they were not overly familiar with the resident and they did not recall any discussions related to interventions with the resident or their family. After reviewing weights for the resident, RD acknowledged that the initial weight change was significant, and that the resident's weight change based on the reweigh, was also significant, but that the reweigh likely did not trigger as a weight exception because it was outside of the 30-day range used by PCC to calculate the weight changes. RD reviewed the progress notes and stated that the significant weight change for the resident was not in a progress note and had not been addressed.

RD was interviewed and shared that significant weight change was a high-risk indicator for a resident, but did not necessarily translate to the resident having an overall high risk. RD said that weight changes were addressed as they triggered in PCC, within a maximum of two weeks. RD explained that PCC automatically calculated 5 per cent, 7.5 per cent, and 10 per cent weight changes and a monthly list was generated with exceptions. RD continued that each of the triggered exceptions were addressed whether or not the weight was accurate. The RD explained that if the reweigh was still significant, a trigger would be regenerated again and they would address it through a progress note but if the reweigh was not significant, there would be no trigger and the RD would not be aware of the reweigh. RD shared that if a resident's weight was more than 2 kg from the previous month, the resident must be reweighed. The RD added that a food service supervisor compared residents' monthly weights and sent lists of those who had to be reweighed up to the units. RD said that when a resident experienced a significant weight change, they would assess the resident, and they would talk to the resident and staff, and then determine the required interventions, based on the assessment. RD acknowledged that whether or not the resident and family were agreeable to interventions, they would document it in the care plan and progress notes. RD reviewed their assessments and progress notes for the resident and stated that a significant weight change was triggered, but the resident was not reweighed until after a period of time when a trigger would be generated in PCC. RD acknowledged that there were no actions implemented nor were interventions considered to address the significant weight change of the resident, as the reweigh was missed by the RD. RD added that if they had considered interventions, they would have been noted in the resident's progress notes

and care plan.

The licensee has failed to ensure that actions were taken for the resident's significant weight change. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: A change of 5 per cent of body weight, or more, over one month; a change of 7.5 per cent of body weight, or more, over three months; a change of 10 per cent of body weight, or more, over 6 months; any other weight change that compromised the resident's health status, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents were protected from abuse by anyone and from neglect by the licensee or staff.

Section 2(1) of Ontario Regulation 79/10 defines sexual abuse as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

The home's policy titled "Zero Tolerance of Abuse and Neglect - 0104-08", last revised September 18, 2017, stated in part:

"The Sun Parlour Home has a "zero tolerance" of abusive behaviour which is strictly enforced. Any employee or volunteer will be disciplined up to and including discharge for any confirmed incident of abuse.
Part A:
Definition of Abuse and Neglect:
This policy uses the definition of "abuse" and "neglect" from the LTCHA, 2007.

The home's policy titled "Intimacy and Sexuality", last revised August 1, 2017, stated in part:
"When intimacy takes on a sexual nature (such as shared sexual touching or intercourse), consent, safety and privacy must be ensured by the LTC home for both residents involved".

The following evidence is further grounds to support the compliance order #001 related to LTCHA, 2007, c.8, s.19(1), issued on March 3, 2017, during the Resident Quality Inspection #2017_566669_0005 with a compliance date of September 29, 2017.

A) A review of two Critical Incident System (CIS) reports indicated that, on two separate occasions, a resident had been touched by another resident in a manner that was considered to be of a sexual nature before staff were able to intervene.

A PSW stated that the resident was known to touch other residents in a sexual manner, and that as a result, several interventions had been put into place to attempt to prevent interactions with other residents.

B) A review of a CIS report identified a resident was observed by staff to be touching another resident in a manner that could be considered to be sexual in nature and was obviously not welcomed by the resident.

The Administrator stated that the sexual behaviours of the resident were long standing and well known and that despite efforts to deter the behaviour, they continued to display sexual behaviours towards other residents. Administrator stated that it was the home's expectation that all residents were protected from abuse by anyone.

The licensee has failed to ensure that residents were protected from sexual abuse by an identfied residents.

C) A review of a CIS report showed that an identified resident had accused a Personal

Support Worker (PSW) of physical and emotional abuse while providing care.

Review of the resident's progress notes showed documentation that the resident had reported to staff that the worker who provided their care was rude and rough, and showed a Registered Nurse reddened areas on the resident's body as a result of the care.

Review of the home's internal investigation notes and interview with the Administrator, revealed that when they concluded their investigation, they found that the staff member did not intentionally harm the resident, but did cause the resident distress and was addressed as a result of the incident.

The licensee has failed to ensure that the resident was protected from physical and emotional abuse by staff. [s. 19. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may have occurred, immediately

reported the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

The following evidence is further grounds to support compliance order #001 related to LTCHA 2007, c.8, s.24(1), issued on October 20, 2017, during Follow Up inspection #2017_566669_0032 with a compliance date of February 1, 2018.

The home's policy titled "Zero Tolerance of Abuse and Neglect - 0104-08" last revised September 18, 2017, was reviewed and stated that staff and management must report all alleged, suspected or witnessed incidents of abuse of a resident by anyone. The policy also said that all incidents of non-consensual sexual behaviour must be reported to the MOHLTC. The policy included that when abuse of a resident by anyone occurred, the action to be taken by the home was to phone the after-hours pager number (when outside of business hours) immediately upon becoming aware of the incident.

A) A review of a Critical Incident System (CIS) report indicated that a resident was observed by staff to be touching another resident.

Review of the clinical record for the resident indicated that staff had identified the issue and had notified the on call Nurse Manager for direction.

The on call Nurse Manager who was notified was interviewed and stated they were aware of and had been notified of this incident, but had included it in a previous CIS report as an amendment, but that this incident should have been reported in a CIS as it's own incident.

Administrator stated during interview that the incident would be considered to be abuse, and should have been reported to the Director in a CIS, not as an amendment to a previous CIS as it was a separate incident.

B) A CIS report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) which reported a resident was verbally abused by a Personal Support Worker.

The resident’s progress notes and risk management notes were reviewed; there was no documentation related to the incident. DOC and Administrator were unable to locate the home’s investigation or interview notes.

There was no evidence to support that the after hours pager had been called and the CIS report was not submitted until two days after the incident had been reported.

Administrator acknowledged that after becoming aware of the incident of alleged staff-to-resident abuse, registered staff should have called the MOHLTC after-hours line right away and submitted a CIS report by the next day.

The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident had occurred immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident System (CIS) report was submitted to the MOHLTC regarding an incident that caused an injury to a resident that resulted in a significant change in the resident's health status.

Review of the home's policy titled "Fall Prevention and Management Program", policy number 0104-01 dated August 15, 2013, stated part of the role of the person witnessing the fall or finding the resident after the fall was to "Not move the resident if there is suspicion or evidence of injury until a full head to toe assessment has been conducted and appropriate action determined (e.g. transfer to hospital)."

Review of the resident's progress notes indicated that a staff member who had witnessed the incident assisted the resident before the resident had been assessed for injury.

A Personal Support Worker (PSW) and a Housekeeping Aide (HA) were interviewed and stated that if they witnessed or suspected an incident, they would check to see if the resident was okay and get help. HA said they would never intervene until directed as nursing staff were responsible for assessment and direction following an incident.

RN said that all staff in the building knew to call a nurse for assessment following an incident and that staff would never intervene until directed.

The Administrator shared that only nurses and PSW's were to be assisting the resident's when they had an incident, and that the role of a person who was not a health care professional was to call for help immediately and stay with the resident, but not to assist the resident. [s. 36.]

WN #7: 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:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information was posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. The required information for the purposes of subsections (1) and (2) included copies of the inspection reports from the past two years for the long-term care home.

During the home's RQI, a tour of the home revealed that not all inspection reports from the past two years were posted.

During the initial tour of the home, the home's previous inspection reports were observed to be posted in a binder on a bulletin board in the hallway just west of the foyer. Inspection reports were reviewed and not all required reports were included in the binder.

Manager of Resident Services and Clinical Practice (MRSCP) was interviewed and acknowledged that reports were missing from the binder and stated they were almost certain this was the only location where reports were posted in the home. MRSCP acknowledged that the identified reports should have been included in this binder.

Administrator was interviewed and acknowledged that the identified reports should have been in the binder and posted within the home.

The licensee has failed to ensure that copies of the inspection reports from the past two years were posted in the home. [s. 79. (3) (k)]

Issued on this 20th day of February, 2018

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

Original report signed by the inspector.