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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 4, 2016	2016_333577_0015	026791-16	Resident Quality Inspection

Licensee/Titulaire de permis

ATIKOKAN GENERAL HOSPITAL
120 DOROTHY STREET ATIKOKAN ON P0T 1C0

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

ATIKOKAN GENERAL HOSPITAL
120 DOROTHY STREET ATIKOKAN ON P0T 1C0

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

DEBBIE WARPULA (577), KATHERINE BARCA (625)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 19, 20, 21, 22 and 23, 2016

Additional logs inspected during this RQI include:

One Follow up log: one previous Compliance order

Two Complaint logs: related to staff qualifications and recreation program;

One Critical Incident log: related to a resident fall.

The inspector(s) conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed resident health care records, and reviewed many of the homes policies, procedures and programs.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CFO), Chief Nursing Officer (CNO), Nurse Manager, Maintenance Engineer, Registered Practical Nurses (RPN), Recreation Therapist, Personal Support Workers (PSW), Family Council President, residents and family members

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **10 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. 6. (8)	CO #001	2015_246196_0008	625

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

Inspector #577 reviewed a Critical Incident (CIS) report that was received by the Director in November 2015, concerning resident #006’s fall that occurred in November 2015, where the resident suffered an injury.

Inspector #577 reviewed resident #006's progress notes and found that this resident had multiple falls over a six month period in 2015. The resident suffered injuries from previous falls.

A review of the home's program titled "Falls Prevention and Management Procedure- 01-10-02" revised March 2015, indicated the following post-fall interventions to be completed by staff after every resident fall:

-complete Risk of Falls Assessment form
-complete Fall Risk Screening Tool
-redo the Fall Risk Assessment
-complete Post Fall Screen for Resident/Environmental Factors
-arrange a care conference for residents who fall frequently; two falls in 72 hours, more than three falls in three months, more than five falls in six months.

A review of the health records for resident #006 revealed inconsistencies with the post fall assessments. 21 per cent did not have a post fall assessment as follows:

-July 2015, incomplete Post Fall Screen
-August 2015, incomplete Post Fall Screen and Fall Risk Screening Tool
-November 2015, incomplete Post Fall Screen

During an interview with the Nurse Manager in September 2016, they reported to Inspector #577 that post fall, staff were required to complete a Risk of Falls Assessment, a Fall Risk Screening Tool, a Fall Risk Assessment and a Post Fall Screen for Resident/Environmental Factors. They further confirmed that the post fall screen and a fall risk screening tool were not consistently completed post fall, and a care conferenc

was not done for resident #006, as required by their Falls program. [s. 8. (1) (a),s. 8. (1) (b)]

2. During a record review, Inspector #577 found that resident #005 had altered skin integrity. Inspector #577 conducted a record review of the physicians orders dated March 2016, which indicated that their treatment was to be re-started, completed as scheduled and as necessary (prn).

A record review of the home’s policy titled “Skin and Wound Care Policy - 01- 30” last revised August 2014, indicated the following:

-for the first dressing change for new or existing wound that re-opened, complete the "Initial Wound Assessment and Documentation Form -01-30-01-04"
-subsequent dressing changes use the "Ongoing Wound Assessment and Documentation Form -01-30-01-05"

A record review of the "Ongoing Wound Assessment and Documentation Form" indicated inconsistencies in the documentation. In April 2016, and June 2016, there was altered skin integrity and treatments were restarted. An Initial Wound Assessment form was not initiated on those dates. According to the policy, the "Initial Wound Assessment and Documentation Form" should have been completed in April 2016, and June 2016, when treatment was restarted.

During a staff interview in September 2016, RPN #101 reported to Inspector #577 that an "Initial Wound Assessment and Documentation Form" was to be completed every time for a new or existing altered skin integrity and the "Ongoing Wound Assessment and Documentation Form" was filled out with every skin treatment.

During an interview with the Nurse Manager, Inspector #577 verified the inconsistencies in documentation. Further, the Nurse Manager confirmed that an "Initial Wound Assessment and Documentation Form" should have been initiated for the existing altered skin integrity in April 2016 and June 2016, and that staff were not following the policy for wound documentation. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

On three days in September 2016, Inspector #625 observed bed rails in the guard position on resident #008's bed.

Inspector #625 reviewed resident #008's health care records from the date of the resident's admission to present, which included multidisciplinary progress notes and the

rehabilitation section of the resident's chart. These records contained no assessment related to the resident's use of bed rails. The resident's current care plan was also reviewed and identified that resident #008 used bed rails. [s. 15. (1) (a)]

2. On two days in September 2016, Inspectors #577 and #625, respectively, observed bed rails in the guard position on resident #009's bed.

Inspector #625 reviewed resident #009's health care record from the date of the resident's admission to present, which included multidisciplinary progress notes, physiotherapy assessments, occupation therapy assessment and the current care plan. These records contained no assessment related to the resident's use of bed rails.

During interviews with Inspector #625, PSW #103 and PSW #104 attended resident #009's room with Inspector #625 and confirmed that bed rails were in the guard position. The PSWs stated that resident #009 used the bed rails for bed mobility, that there was no order for the use of the bed rails, and that they were not listed in the resident's care plan as it was the resident's preference to use the bed rails.

During an interview with RPN #105, they stated that the resident used bed rails and that the resident's use of the bed rails should be included in their care plan. The RPN stated that they had never documented an assessment of the use of bed rails by residents in the home. [s. 15. (1) (a)]

3. On two days in September 2016, Inspector #625 observed bed rails in the guard position on resident #007's bed.

Inspector #625 reviewed resident #007's health care record from the date of the resident's admission to present, which included multidisciplinary progress notes and physiotherapy notes. These records contained no assessment related to the resident's use of bed rails. Resident #007's current care plan was also reviewed and indicated that the resident used bed rails.

During an interview with resident #007's family members #106 and #107, they stated that they were not sure why the bed rails were raised, that staff had not spoken to the family about the use of the bed rails, and that the resident used bed rails to assist with bed mobility.

During an interview with Inspector #625, PSW #103 stated that resident #007 used bed

rails for mobility in bed. PSW #104 attended resident #007's room with Inspector #625 and confirmed that bed rails were in the guard position. The Inspector asked PSW #103 about resident #007's care plan that indicated the resident used bed rails. PSW #103 then stated that they guessed that resident #007 only needed one bed rail raised for bed mobility.

During an interview with the Nursing Manager, they stated that the home did not formally assess residents' use of bed rails. They reported that the staff would discuss residents' bed rail use and include that information in residents' care plans, but a documented assessment of bed rail use did not occur.

During an interview with Inspector #625 on a day in September 2016, Maintenance Engineer #102 stated that the home did not assess or evaluate the bed systems, the home's beds were ordered through a group purchasing consortium and that bed system evaluations were not conducted on the new beds. They also acknowledged that bed system evaluations were not completed on older bed systems in the home when bed components such as mattresses were changed, or when new residents were admitted to the home. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident, specifically in regards to resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that, without in any way restricting the generality of the duty provided for in section 19, there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

Inspector #625 conducted an interview with resident #007's family members #106 and #107, who reported that approximately one year ago, RPN #105 was disgruntled towards resident #007. Family members #106 and #107 reported that RPN #105 had reprimanded resident #007 and that the family found it to be abusive. They stated that the RPN was upset at resident #007, causing resident #007 to become upset. Family members #106 and #107 stated that, after the incident, they told a Personal Support Worker (PSW) whose name they did not recall what had occurred, and that the PSW then told RPN #105 who approached the family members about the incident.

Ontario Regulation 79/10 defines abuse to be any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminished a resident's sense of well-being, dignity or self-worth, that was made by anyone other than a resident.

A review by Inspector #625 of the Critical Incident System reports submitted by the home in 2015 and 2016 identified that a Critical Incident System report had not been submitted by the home related to the incident described by family members #106 and #107.

A review of the home's policy titled "Zero Tolerance of Abuse and Neglect – 01-15" last revised November 2014, identified that staff were required to report all alleged, suspected or witnessed incidents of abuse of a resident by anyone, and that internal reporting procedures and reporting procedures to the Ministry of Health and Long-Term Care were required, using the Critical Incident System.

A review of the home's policy titled "Zero Tolerance of Abuse and Neglect– 01-15" last

revised November 2014, indicated that all alleged, witnessed or suspected reports of abuse, must be reported.

A review of the home's policy titled "Staff Reporting and Whistle-Blowing Protection- 04-09-01" last revised November 2014, indicated that all reports should be made to a staff member's immediate supervisor or manager and, where an immediate supervisor was implicated, the report should be made to the next level of leadership or a member of senior management.

During an interview with the Nursing Manager on a day in September 2016, they stated that the way the RPN #105 spoke to resident #007 constituted verbal abuse and that the PSW should not have spoken to RPN #105 about the incident. They stated the PSW should have notified them of what happened, by following the home's abuse polices, and confirmed that this incident was not reported to management. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, specifically in regards to resident #007, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 47. Qualifications of personal support workers

Specifically failed to comply with the following:

s. 47. (1) Every licensee of a long-term care home shall ensure that on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title,
(a) has successfully completed a personal support worker program that meets the requirements in subsection (2); and
(b) has provided the licensee with proof of graduation issued by the education provider. O. Reg. 399/15, s. 1.

Findings/Faits saillants :

1. The licensee has failed to ensure that every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title has successfully completed a personal support worker program that meets the requirements.

A complaint was received by the Director in October 2015, alleging that the home had employed staff who did not have the PSW designation.

On a day in September 2016, Inspector #577 requested employee files from the Manager to confirm certifications of all employed PSW's.

During a record review of employee files on a day in September 2016, the Inspector found one employee who had completed a Developmental Services Worker program in 2015.

During an interview with the Manager, they revealed to Inspector #577 that DSW #111 was currently employed as a PSW and had not completed a PSW program. They further confirmed that the Chief Nursing Officer (CNO) #110 had assumed that DSW #111 was qualified to work as a PSW. [s. 47. (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 person hired by the licensee as a personal support worker or to provide personal support services, regardless of title has successfully completed a personal support worker program that meets the requirements, to be implemented voluntarily.

WN #5: 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, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During record review, Inspector #577 found that resident #005 had altered skin integrity.

Inspector #577 conducted a record review of the physicians orders dated March 2016, which indicated that a skin treatment was to be re-started and changed every three days and as necessary (prn).

A review of the home's policy titled "Skin and Wound Care Procedure – 01 -30 – 01" revised date August 2014, indicated that after a skin treatment, staff were to complete the Wound Assessment Record weekly.

A further record review of the Ongoing Wound Assessment and Documentation forms indicated inconsistencies, where there were no assessments by registered staff completed for two weeks in April 2016, and there was further altered skin integrity.

During a staff interview on a day in September 2016, RPN #101 reported to Inspector #577 that the Wound Assessment and Documentation form was documented with every skin treatment.

During an interview with the Manager, Inspector #577 confirmed the inconsistencies in the skin assessment in April 2016, and they reported that the Ongoing Wound Assessment and Documentation forms should have been completed with each wound assessment. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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, specifically in regards to resident #005, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responded in writing within 10 days of receiving Resident Council advice related to concerns or recommendations.

Inspector #577 reviewed the Resident Council Meeting Minutes from September 2015-September 2016, which identified concerns, as follows:

September 2015
-cold temperatures
-evening quiet time

March 2016
-chair heights
-washroom set up
-personal telephone
-adding more card games
-residents assisting with yard work

June 2016
-incontinence at night and showering

September 2016
-adding outside activities
-missing clothing

During an interview with the Recreation Therapist #108 on a day in September 2016, they reported that they were the assistant to the Council and posted the meeting minutes on the Resident Council board within one to two weeks. They reported that any concerns or recommendations made by the Council was brought forward to the Nurse Manager the same day of the Resident Council meeting. They further confirmed that the Council has not received a written response within 10 days, or at all, and they followed up with a verbal response to individual residents. They stated that the meeting minutes from the September 2016, meeting were not posted yet.

During an interview with the Nursing Manager on a day in September 2016, they confirmed that the Resident Council has not received a written response to their concerns or recommendations within 10 days of receiving the advice from Resident Council. [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that that the licensee responds in writing within 10 days of receiving Resident Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Recreation program includes recreation and social activities that included a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests.

A complaint was received by the Director in December 2015, concerning a lack of recreation activities and poor quality of activities for residents in the home. Activities had decreased to one activity per day, were frequently canceled and activities were done by volunteers.

During resident interviews on a day in September 2016, Inspector #577 found the following:

- resident #012 reported that there were no activities offered during the evening or weekends and did not find the recreation activities interesting
- resident #009 reported they were not sure whether the home offered evening or weekend activities and did not find the recreation activities interesting
- resident #003 reported they were not sure whether the home offered weekend activities and did not find the recreation activities interesting
- resident #008 reported there were no weekend activities offered
- resident #013 reported that there were no weekend activities offered
- resident #002 reported they were not sure whether the home offered evening activities

The Inspector spoke with the complainant on a day in September 2016, who reported that there were limited activities for residents, there were many cancelled activities and residents were bored most of the time.

On a day in September 2016, Inspector #577 reviewed the resident's recreation calendars from July-September 2016, and found the following:

-July 2016, indicated three evening activities and one weekend activity for the month
-August 2016, indicated one evening activity and one weekend activity for the month
-September 2016, indicated one evening activity and one weekend activity for the month

On two days in September 2016, Inspector #577 conducted an interview with Recreation Therapist #108 who reported that they had recreation activities Monday to Friday, two activities per day or four smaller activities; evening and weekend activities were based on volunteer activities. They further reported that the volunteer comes to the home and visits with residents and has tea. The one weekend activity involved a visit from the Mennonite singers and the one evening activity involved hymn time. [s. 65. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Recreation program includes recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Family Council was sought in developing and carrying out the home's satisfaction survey, and in acting on its results.

A review by Inspector #625 of the "Family Council President or Delegate Questionnaire" indicated that a representative of the licensee or a designate did not request advice from the Family Council on the development and carrying out of the Resident/Family Yearly Satisfaction Survey and in acting on survey results.

During an interview with the Nursing Manager they stated that the Family Council had not been consulted in the development and carrying out of the satisfaction survey. They were not sure if advice was sought from the Family Council in acting on the survey results.

During an interview with the Recreation Therapist #108, they stated that a copy of the results of the 2015 satisfaction survey were left in a file for the Family Council on December 7, 2015, but that the Family Council was not consulted about developing and carrying out the home's satisfaction survey or acting on its results.

During an interview with the Family Council President #109, they stated that the Family Council had not been consulted on the satisfaction surveys prior to its distribution, and that they had not been aware that the Family Council had a role in the acting on the survey results. [s. 85. (3)]

2. The licensee has failed to ensure that the advice of the Residents' Council was sought in developing and carrying out the survey, and in acting on its results.

During an interview with the Recreation Therapist #108 on a day in September 2016, they reported that they were the assistant to the Residents' Council and the most recent satisfaction survey results were shared with the Residents' Council in August 2015. They further reported that the home did not seek advice from the Council in developing and carrying out the home's satisfaction survey or acting on its results.

During an interview with the Nursing Manager on a day in September 2016, they confirmed that the home did not seek advice from the Residents' Council concerning satisfaction surveys. [s. 85. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the advice of the Family Council and Residents' Council is sought in developing and carrying out the home's satisfaction survey, and in acting on its results, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

During a tour of the home on a day in September 2016, Inspector #625 observed the following hazardous chemicals accessible to residents:

- Oster Kool Lube 3 clipper blade coolant, lubricant and cleaner which displayed Workplace Hazardous Materials Information System (WHMIS) symbols for Flammable and Combustible Materials (Class B) and Materials Causing Other Toxic Effects (Class D - Division 2); and Wahl Blade Ice which displayed WHMIS symbols for Flammable and Combustible Materials (Class B), Materials Causing Immediate and Serious Toxic Effects (Class D – Division 1) and a consumer product symbol identifying the container as pressurized in the Resident Lounge/Hairdressing Area in an unlocked cupboard;

- Comet Deodorizing Cleanser which displayed a WHMIS symbol for Materials Causing Other Toxic Effects (Class D – Division 2) in an unlocked cupboard in the resident kitchen;

- Virex II 256 One-Step Disinfectant Cleaner and Deodorant which displayed a WHMIS symbol for Materials Causing Immediate and Serious Toxic Effects (Class D – Division 1)

and a consumer product symbol for corrosive material; Easy Paks Neutralizer which displayed a WHMIS symbol for Materials Causing Other Toxic Effects (Class D – Division 2) Comet Deodorizing Cleanser which displayed a WHMIS symbol for Materials Causing Other Toxic Effects (Class D – Division 2); PERdiem General Purpose Cleaner with Hydrogen Peroxide which displayed a WHMIS symbol for Materials Causing Other Toxic Effects (Class D – Division 2) in the unlocked Janitor Closet.

- Deep Gloss which displayed a WHMIS symbol for Flammable and Combustible Materials (Class B) on the unlocked Housekeeping Cart.

A review of the home's policy "Housekeeping Carts - 01-47-01", last revised June 2016, indicated that all chemicals and supplies were to be stored on shelves in a tidy and orderly manner, with the door locked at all times, and no chemicals left on top of the cart.

A review of the home's policy "Housekeeping Equipment Safety- 01-46-01", last revised February 2015, identified that Housekeeping Carts were not to be left unattended and, when not in use, all chemicals would be stored in the locked compartment on the cart.

During interviews with Inspector #625, the Director of Care stated that the hazardous chemicals that had been accessible to resident in the Resident Lounge/Hairdressing Area, and under the unlocked resident kitchen sink cupboard, should have been removed from those areas or locked. The DOC also stated that the Janitor Closet and Housekeeping Cart should have been locked to ensure hazardous chemicals were not accessible to residents." [s. 91.]

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 all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

On a day in September 2016, Inspector # 625 observed the home's medication cart, which contained medications for the residents in the home, to have a non-functioning lock.

During an interview with Inspector #625 on a day in September 2016, RPN #101 attempted to lock the medication cart but was not able to, and stated that the lock was stiff and would not turn to lock.

During the lunch meal service on a day in September 2016, Inspector observed RPN #101 administer medications to residents, while the unlocked medication cart was located in the resident lounge. The RPN was unable to view the medication cart during administration of medication in the dining room.

During an interview with Inspector #625 on a day in September 2016, the Nursing Manager confirmed that the medication cart, which contained medications for residents, was being used in the resident lounge and could not be locked. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate

locked area within the locked medication cart.

On a day in September 2016, Inspector #625 observed the home's medication cart, which contained a separate drawer adjacent to the other medications for controlled substances, to be locked with only one lock. The Inspector observed that the medication cart did not contain a second lock on or in the drawer where controlled substances were stored.

During an interview with Inspector #625 on a day in September 2016, RPN #101 confirmed that the single lock on the drawer housing the controlled substances was the only operational lock on the medication cart.

During an interview with Inspector #625 on a day in September 2016, the Nursing Manager confirmed that the controlled substances located on the medication cart were locked in a locked drawer area within the medication cart, and only had one lock. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart that is secure and locked; and to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

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

Issued on this 28th day of December, 2016

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

Original report signed by the inspector.