Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Jun 16, 2015	2015_266527_0011	H-002394-15	Resident Quality Inspection

Licensee/Titulaire de permis

488491 ONTARIO INC
689 YONGE STREET MIDLAND ON L4R 2E1

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

AVALON RETIREMENT CENTRE
355 BROADWAY AVENUE ORANGEVILLE ON L9W 3Y3

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

KATHLEEN MILLAR (527), DARIA TRZOS (561), MICHELLE WARRENER (107), SUSAN PORTEOUS (560)

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): May 13, 14, 15, 19, 20, 21, 22, 25 and 26, 2015

In addition, Susan Porteous (560), Long Term Care Inspector, participated as a member of the Resident Quality Inspection (RQI) team.

The following Critical Incidents were inspected concurrently with the Resident Quality Inspection (RQI): H-002095-15, H-002280-15, H-002614-15, H-002343-15, H-001567-14, H-01812-15, and H-002552-15. In addition, the following inquiries were conducted concurrently with the RQI: H-002573-15, H-002578-15, and H-2572-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Co-Directors of Care, the Staff Educator, the Administrative Assistant, the Environmental Services Manager, the Life Enrichment Coordinator, the Restorative Care Coordinator, the Food Services Manager, the Resident and Family Services Coordinator, the Registered Dietitian, the Minimum Data Set (MDS)Resident Assessment Instrument (RAI) Coordinator, the Nurse Practitioner, the Physiotherapist, Registered staff, Personal Support Workers, Dietary Aides, Housekeeping Aides, residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

16 WN(s)
12 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

Findings/Faits saillants :

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

A) The plan of care for resident #007 included interventions to prevent co-residents from wandering into their room. The intervention was observed to be in place, but the intervention was not documented in the written plan of care. The PSWs confirmed the intervention was implemented. The registered staff confirmed the written plan of care for resident #007 did not include the intervention. The Co-Director of Care was interviewed and confirmed the intervention for resident #007 was implemented, and was expected to be documented in the written plan of care. (560)

B) Resident #036 had two falls in the month of April 2015. One of the interventions recommended to prevent the resident from falling was identified in the clinical record. The recommended intervention was to place the resident's bed in the lowest position. The PSWs and Restorative Care Coordinator were interviewed and identified that the bed was placed in the lowest position for the resident as one of the interventions to prevent the resident from falling. The bed was observed in the lowest position in May 2015. The written plan of care was reviewed and did not include the bed to be in lowest position as one of the falls prevention interventions. The DOC confirmed that the intervention was not documented in the written plan of care. (561)

C) The home revised the written plan of care post-fall for resident #009. The written plan of care dated April 2014 for resident #009 identified falls prevention interventions to be implemented. The same written plan of care also identified falls prevention interventions that were not implemented or were discontinued. The LTC Inspector observed the resident and confirmed what falls prevention interventions were implemented. The PSW was interviewed and confirmed the falls prevention interventions that were implemented and the written plan of care was unclear. The Co-Director was interviewed and confirmed that the falls prevention interventions identified on the written plan of care were confusing and unclear for staff. (560) [s. 6. (1) (a)]

2. The licensee failed to ensure that the care set out in the plan of care for resident #026 was based on an assessment of the resident and the needs and preferences in relation to bathing.

Equipment was stacked in the shower area of the shower/tub room on the first floor,

making access to the shower area more difficult than the tub area. During an interview, one PSW stated all residents were provided with a tub bath, not a shower.

Resident #026 voiced a preference to the Long Term Care (LTC) Inspector for showering versus bathing. A different staff member confirmed that the resident preferred showering; however, the resident's written plan of care that provided direction to staff stated the resident preferred a bath, not a shower.

The resident's written plan of care was not based on the resident's preferred method of bathing. [s. 6. (2)]

3. The licensee has failed to ensure that staff and others involved in the different aspects of care for resident #042 and resident #020 collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other in relation to continence.

A) Information on the Minimum Data Set (MDS), Resident Assessment Instrument (RAI), the Resident Assessment Protocols (RAPS), and the written plan of care, were not consistent in relation to the resident's level of continence for both bowel and bladder.

The MDS for the admission assessment in October 2014, identified the resident was occasionally incontinent of bowels and occasionally incontinent of bladder. The January 2015, MDS assessment identified the resident was occasionally incontinent of bowels and frequently incontinent of bladder. The assessment identified no change in bladder continence despite a deterioration from occasionally incontinent to frequently incontinent.

The March 2015, MDS assessment identified the resident was frequently incontinent of bowels and frequently incontinent of bladder. The written plan of care for the same time period identified the resident was fully continent of bowels and did not indicate the level of bladder incontinence. The progress notes, the MDS assessment, and the RAPs did not indicate the reason for the discrepancies.

During an interview the Registered Practical Nurse (RPN) and the Registered Nurse (RN) confirmed the information was not consistent between the assessments and could not identify why the documents were inconsistent.

The assessments were not consistent in relation to the resident's level of incontinence.

B) The information on the MDS assessment, the RAPs, and the written plan of care for resident #020, were not consistent in relation to the resident's level of continence for both bowel and bladder.

The MDS assessment for the resident's admission in December 2014, identified the resident was occasionally incontinent of bowels and frequently incontinent of bladder. The March 2015, MDS assessment identified the resident was continent of bowels and completely incontinent of bladder. The assessment identified no change in bladder continence despite a deterioration from frequently incontinent to completely incontinent.

The RAP for the March 2015, and the MDS assessment identified the resident was frequently incontinent of bladder, which was not consistent with the assessment completed at the same time. The written plan of care for the same time period identified the resident was occasionally incontinent of bowels and frequently incontinent of bladder. The progress notes and RAPs did not indicate the reason for the discrepancies.

During an interview the RPN and RN confirmed the information was not consistent between the assessments and could not identify why the documents were inconsistent.

The assessments were not consistent in relation to the resident's level of incontinence.

C) Resident #036 had a change in bladder incontinence according to the MDS quarterly assessment dated September 2015 from being occasionally incontinent to frequently incontinent. The written plan of care was reviewed and did not identify the level of bladder incontinence. The Lead for Continence Care in the home confirmed that the staff did not document the level of bladder incontinence in the written plan of care for the resident when there was a change. The staff did not ensure that they collaborated with each other in the development and implementation of the plan of care for the resident, and did not ensure that the written plan of care was consistent with the MDS quarterly assessment when the resident had a change in condition. [s. 6. (4) (a)]

4. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A) The plan of care for resident #003 identified the resident was participating in the Restorative Care Program for dressing and grooming. The written plan of care identified that one staff member was to provide the supplies for the resident to complete oral care in the morning and evening. The written plan of care also identified restorative care

interventions that staff were to implement. The resident was observed by the LTC Inspector in May 2015 with the upper denture not fitting properly and mouth debris present. Several days later, the resident had no dentures in place and the dentures were found in a cup of water in the bathroom. The PSWs were interviewed and they confirmed that the care set out in the plan was not being provided to the resident as specified due to the resident's change in condition. The RNs were interviewed and they confirmed the care that was supposed to be provided as identified in the written plan of care, and that they were not aware that the PSWs were not providing the care to the resident as specified in the plan.

B) The MDS Assessment and the written plan of care for resident #030 identified that the resident required two staff to assist with safe transferring and toileting. The resident was observed by the LTC Inspector in May 2015 being toileted with one PSW. The PSW was interviewed and identified that the resident only required one person to assist and the resident uses the grab bars beside the toilet to assist with transferring to the toilet. The transfer logo in the resident's bed room identified a two person transfer was required for the resident. The DOC confirmed that the resident was a two person transfer and the care set out in the plan was not provided to the resident as specified.

C) Resident #036 had two falls in the month of April 2015 and one fall in the month of May 2015. The resident was considered at high risk for falling. The written plan of care identified falls prevention interventions. In May 2015, the resident was observed by the LTC Inspector in bed with no wall alarm implemented. The alarm could not be found in the resident’s room by staff. The registered staff and the Restorative Coordinator confirmed that the laser alarm should have been attached to the wall as identified in the plan of care.

D) Resident #016 required to have their blood sugar checked as per the physician's order. The resident had a physician's order for insulin based on the blood sugar (BS) results. In April 2015 the blood sugars were not checked for resident #016 on two days. The medication administration record (MAR) identified that the resident was sleeping, yet the blood sugar was not checked when the resident woke up. The Co-Director of Care was interviewed and confirmed that it was an expectation that the blood sugar levels were checked after the resident woke up.(561) [s. 6. (7)]

5. The licensee has failed to ensure that the outcomes of the care set out in the plan of care was documented.

Resident #016 required to have their Blood Sugar checked as per the physician's order. The Medication Administration Record (MAR) was reviewed for May and April 2015. On a specific date in April 2015 the Blood Sugar level was not documented in Point Click Care (PCC), or documented on the 24 hour shift report. The Co-Director of Care was interviewed and identified that it was an expectation that the blood sugar levels were documented in PCC. [s. 6. (9) 2.]

6. The licensee has failed to ensure that the resident's plan of care was revised at the time when the resident's care needs changed or care set out in the plan was no longer necessary.

Resident #036 had a change in bowel continence. The MDS quarterly assessment completed in September 2014, identified the resident was frequently incontinent of bowels. The resident's written plan of care identified that the resident was continent and had complete control of bowels. The Lead for Continence Care in the home reported that the written plan of care was not revised when the resident had a change in bowel continence. [s. 6. (10) (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 there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident. To ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. To ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other. To ensure that the care set out in the plan of care is provided to the resident as specified in the plan. To ensure that the outcomes of the set out in the plan of care is documented. To ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The home’s policy called "Falls Prevention and Management Program", version 2, revised March 2015, identified that “registered staff will ensure that, a resident who has a fall, has Head Injury Routine initiated if head injury is evident or if fall is unwitnessed”.

Resident #036 had two falls in April and one fall in May 2015. The clinical record and interviews with staff identified that after the fall in April and May 2015, the Head Injury Routine (HIR) was not initiated. A registered staff member reported that the HIR was only for residents who were cognitively impaired, and who had an unwitnessed fall. The Administrator was interviewed and identified that the staff were expected to comply with the home’s policy and should have initiated the Head Injury Routine for the unwitnessed falls for resident #036.

B) The Classic Care policy called “Ordering Leave of Absence Medications”, policy number 2.8, revised July 2014, identified "for narcotic and controlled substances required for LOA's, the nurse should follow their Home-specific Policy; if a Home-specific Policy is not available, Classic Care Pharmacy recommends that a separate LOA narcotic prescription is obtained from the prescriber and dispensed accordingly".

Resident #044 went on a Leave of Absence (LOA) in April 2015 with their family and returned to the home three days later. The medication card with the tablets that was sent with the resident when she went on LOA was not returned to the home. When the resident went on the LOA the home did not follow the Classic Care policy, and did not obtain a separate LOA narcotic prescription. All the tablets in the medication card were sent with the resident.

The Administrator confirmed that there was no internal policy in relation to sending medication with residents that are going on a LOA, and the staff were expected to comply with the Classic Care Policy. [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 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 all applicable requirements under the Act, and (b) is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
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; O. Reg. 363/11, s. 1 (1, 2).

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to stairways were: 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. was connected to the resident-staff communication and response system, or B. was connected to an audio visual enunciator that was connected to the nurses' station.

The basement stairwell located beside the washrooms was not equipped with a door access control system. Residents attended recreational programming and various activities in the basement and staff confirmed residents would be able to access the identified stairwell. [s. 9. (1)]

2. The licensee failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

In May 2015 during the initial tour of the home by the LTC Inspector, the housekeeping and linen room doors on the first floor were observed to be unlocked and unsupervised by staff. In addition, the service door to the kitchen and laundry was observed propped open and unsupervised. The LTC Inspector observed signage outside of the service door, which directed staff to keep doors closed at all times when unsupervised. The staff were interviewed and confirmed that these doors were expected to be locked at all times, when unsupervised. The Administrator was interviewed and also confirmed the doors should have been closed and locked at all times, when unsupervised. (560) [s. 9. (1) 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 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. In addition, all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, 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:

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. O. Reg. 79/10, s. 30 (1).
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. O. Reg. 79/10, s. 30 (1).
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. O. Reg. 79/10, s. 30 (1).
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).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to 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: 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.

The written plan of care for resident #003 identified the resident had potential to restore function to maximum self-sufficiency for personal hygiene, which included mouth care. The written plan of care also identified the restorative interventions. The resident was observed on three specific dates in May 2015 with their restorative care interventions not implemented. The PSWs for the day and evening shift were interviewed and they identified the resident's condition had declined and the resident was not participating in the restorative care program. Two RNs were interviewed and they were not aware that the resident was not able to participate in the restorative care program.

The DOC and Administrator were interviewed and identified the home had not annually evaluated and updated the Restorative Care Program and were not able to provide a written record related to the evaluation, a summary of the changes made, and/or the date they were implemented. [s. 30. (1) 3.]

2. The licensee has failed to ensure that actions taken with respect to resident #040, under the nursing and personal care program related to oral hygiene, including the resident's responses to interventions, were not documented in May 2015.

A) The PSW providing care to resident #040 stated the resident refused oral care on a specific day in May 2015. Documentation in the Point of Care (POC) system the same day identified oral care was provided and signed as completed. The PSW confirmed the resident did not receive oral care and had refused that day. After discussion with the LTC Inspector the PSW revised the documentation to "refused". The documentation in the resident's clinical record did not reflect the resident's response to the offer of oral hygiene when the resident refused.

B) The PSW providing care to resident #029 stated the resident refused oral care on a specific day in May 2015. Documentation in the POC system the same day identified oral care was provided and signed as completed. The PSW confirmed the resident did not receive oral care and had refused. After discussion with the LTC Inspector in relation to the resident's oral care, the PSW revised the documentation to reflect "refused". The documentation in the resident's clinical record did not reflect the resident's response to the offer of oral hygiene when the resident refused. The resident was identified to have mouth odour and white debris on their teeth two days in May 2015. [s. 30. (2)]

3. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented.

A) Resident #041 was assessed as requiring oxygen therapy continuously and to maintain oxygen saturation as per the physician's order. The clinical record was reviewed and identified the resident was receiving oxygen therapy continuously. The registered staff were interviewed and confirmed the written plan of care identified that the oxygen saturation was to be maintained at a specific level. The registered staff also identified that they were expected to document the oxygen saturation on every shift in the "Weights and Vitals Summary" in the Point of Care (POC) electronic documentation system. The "Weights and Vitals Summary" in the POC electronic documentation system was reviewed and identified that documentation of the oxygen saturation was inconsistent on every shift, and there were gaps of no documentation of the oxygen saturation ranging from 3 to 30 days over the past six months. The Registered staff confirmed that they were not documenting the interventions as expected.

B) Resident #038 was assessed as requiring oxygen therapy continuously and to maintain oxygen saturation as per the physician's order. The resident had been admitted to the hospital with breathing difficulties. The clinical record was reviewed and identified the resident was receiving oxygen therapy continuously. The registered staff were interviewed and confirmed the written plan of care identified that the oxygen saturation was to be maintained at a specific level. The registered staff also identified that they were expected to document the oxygen saturation on every shift in the "Weights and Vitals Summary" in the Point of Care (POC) electronic documentation system. The "Weights and Vitals Summary" in the POC electronic documentation system was reviewed and identified that documentation of the oxygen saturation was inconsistent on every shift, and there were gaps of no documentation of the oxygen saturation ranging from 3 to 30 days over the past six months.The Registered staff confirmed that they were not documenting the interventions as expected. [s. 30. (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 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: 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. In addition, the licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, 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).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff.

Resident #016 had a pressure ulcer. The clinical record was reviewed and identified that the resident was not assessed for 3 weeks during the month of April 2015. There was an assessment done at the beginning and end of April 2015. The interview with the registered staff identified that the residents with wounds were required to be assessed on the days that a dressing was changed and by a Wound Care nurse every two weeks. The interview with the Wound Care nurse identified that it was the home's expectation that the weekly assessments were done for residents with wounds and confirmed that they were not consistently done on weekly basis. The home's policy called "Skin and Wound Care Program", effective September 2013, identified that registered staff "will ensure that a resident with actual alteration in skin integrity including skin breakdown, pressure ulcers, skin tears or wounds; has a completed wound progress note, weekly, if

altered skin integrity is a wound. This will reflect the weekly assessment of the resident related to wound status”. The home did not ensure that the resident received weekly wound assessments by registered staff.

B) Resident #037 had pressure ulcers. The clinical record was reviewed and identified that the resident did not consistently receive an assessment of wounds on a weekly basis. The interview with registered staff identified that residents with wounds were required to be assessed on the days that a dressing was changed and by a Wound Care nurse every two weeks. The interview with the Wound Care nurse identified that it was the home’s expectation that the weekly assessments were done for residents with wounds and confirmed that they were not consistently done on weekly basis.

C) The clinical progress notes for resident #030 identified a pressure area documented in April 2015. A progress note by the Nutrition Manager also in April 2015, identified a pressure ulcer. The resident was receiving a treatment cream for the identified area; however, staff confirmed there were no weekly assessments completed of the area.

Staff confirmed the resident continued to have the pressure area that they were treating with treatment cream as of May 2015. The home's policy related to wounds stated that all pressure areas would be assessed weekly. The Wound Care nurse confirmed that skin areas were not being assessed weekly as per the home's policy. (107) [s. 50. (2) (b) (iv)]

2. The licensee has failed to ensure that equipment, supplies, devices and positioning aids were readily available as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

Resident #016 had pressure ulcers. The written plan of care identified the pressure relieving interventions. The registered staff were interviewed and identified the cause of the pressure ulcer. The registered staff identified that the resident required a different size bed. The interview with the Administrator identified that he was not aware of this issue. The home did not ensure that the resident received the equipment required to relieve pressure from their wound. [s. 50. (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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, and the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment that was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

A) The home's policy, "Resident Rights, Care and Services - Required Programs - Continence Care and Bowel Management Program", revised March 2015, identified that additional "assessment for continence" is completed with any decline in bowel and or bladder continence identified in the MDS assessment. Resident #042 had a decrease in their continence from occasionally incontinent to frequently incontinent of bladder from October 2014 to January 2015. Registered staff confirmed that an "assessment for continence" was not completed as expected.

B) Resident #036 had a change in continence from being occasionally incontinent of bowels and bladder to frequently incontinent of bowels and bladder as identified in their September 2014 MDS quarterly assessment. The clinical record was reviewed and identified that the resident was not assessed when there was a decline in bowel incontinence.

The home's policy called "Continence Care and Bowel Management Program", version 2, revised March 2015, identified that "registered staff shall ensure that each resident receives, on admission, an "assessment for continence" (urinary and bowel) under PCC assessments and additional "assessment for continence" is completed with any decline in bowel and/or bladder continence indicated in completing the MDS-RAI coding".

The DOC and the Lead for Continence Care in the home confirmed that the staff should have assessed the resident using an "assessment for continence" tool in PCC when there was a change in the resident's incontinence as identified through the MDS assessment. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident who was incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure there was a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration for resident #036.

Resident #036 was at nutritional risk related to nutrition and hydration. Documentation of the resident's consumption of the evening snack was incomplete between April to May 2015. The evening snack was not recorded for eight days in April, and ten days in May 2015. Staff were not monitoring the intake and due to the large amount of missing documentation, an evaluation could not be completed in relation to the resident's intake of the evening snack. [s. 68. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the programs include a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the food production system included preparation of all menu items according to the planned menu on May 13, 2015.

A) The planned therapeutic extension menu required raspberry mousse instead of sherbet for residents requiring a diabetic menu and for those residents requiring thickened fluids. Residents requiring those diets were served the lime sherbet which was contraindicated on the therapeutic extension menu. The Cook confirmed that the raspberry mousse was not prepared and available for the meal service as per the planned menu.

The Food Committee meeting minutes for May 2015, identified concerns that menus and production sheets were not always followed by staff and that some of the minced and pureed menu items were not available for service.

B) Residents requiring thickened consistency fluids received fluids of varying consistency at the same meal. Some examples included: the lunch meal on a specific day in May 2015, the water and cranberry juice were labeled as honey thick fluids and were the consistency of pudding (turned on side and barely moved); another resident with thickened fluids had fluids labeled as honey thick but their water was pudding consistency and the milk was honey consistency. At the lunch meal on another day in May 2015, the juice served to residents was the same consistency for those receiving nectar consistency thickened fluids, and those receiving honey consistency thickened fluids. Staff confirmed the fluids at the table were not the same consistency. [s. 72. (2) (d)]

2. The licensee has failed to ensure that all food and fluids were prepared and served using methods that preserved taste, nutritive value, appearance and food quality at a lunch meal in May 2015.

The texture of the pureed garden salad, pureed red cabbage salad, and pureed bread were too thin and were running into other items on the plate, resulting in reduced nutritive value (too much fluid) and appearance. The Nutrition Manager confirmed the items were too thin.

Documentation from the Food Committee meeting minutes December 2014, reflected concerns from residents related to pureed foods being too runny and visually unappealing. [s. 72. (3) (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 the food production system must at a minimum, provide for preparation of all menu items according to the planned menu, and to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff provided safe positioning for resident #052 at the lunch meal in May 2015. The resident was observed to be slightly reclined in their wheelchair. The PSW assisting the resident with eating stated that the resident was difficult to position and their chair was not placed fully upright due to the resident's condition. The Registered Dietitian (RD) confirmed the resident was to have a pillow placed behind them for correct positioning during meals. Direction related to positioning or positioning aides during meals was not included in the resident's written plan of care. [s. 73. (1) 10.]

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 home has a dining and snack service that includes, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance, 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 complied with manufacturer's instructions for the storage of the drugs (e.g. expiration dates).

During the observation of the medication pass on a specific day in May 2015, there were two medications found in the medication cart that were expired. The medications were part of the government stock. The medications expired in March 2015. The DOC confirmed that these medications should have been disposed of. [s. 129. (1) (a)]

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

In May 2015, a prescription cream for resident #051 was left sitting on the resident's bed side table. The room was vacant and the door to the room was open. The PSW providing care to the resident confirmed the cream had been left at the bedside after morning care, and prescription creams were not supposed to be left at the bedside of residents. [s. 129. (1) (a) (ii)]

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 were stored in an area or a medication cart that is secure and locked, and complies with the manufacturer's instructions for the storage of the drugs, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Resident #038 and #041 were ordered oxygen therapy whenever necessary. The residents were observed by the LTC Inspector over a two week period in May 2015, receiving oxygen therapy continuously. The physician's orders and the medical directives were reviewed and there was no order for oxygen therapy continuously. The registered staff were interviewed in May 2015, they confirmed the residents were receiving oxygen therapy continuously and there was no physician's order. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program as evidenced by the following:

The Tub room on 1N and 2N were observed to have a pair of unlabelled nail clippers on a storage counter. All residents had a labelled container in the Tub room for storing their nail clippers. The identified clippers were not stored in the appropriate container. Staff confirmed that the clippers were unlabelled and not in the appropriate container and discarded them. [s. 229. (4)]

2. The licensee has failed to ensure that all staff participate in the implementation of the Infection Prevention and Control (IPAC) Program.

A) In May 2015, the home had identified eleven residents with infections. The Public Health Department for the region declared a facility wide outbreak. There were several residents placed on Contact and Droplet isolation.

(i) In May 2015, a PSW was observed in a resident's room with no Personal Protective Equipment (PPE) and the resident was identified as being on Contact and Droplet precautions. The PSW was interviewed and confirmed they were expected to wear PPE when providing care to the resident. The Infection Prevention and Control (IPAC) Lead and the Administrator confirmed staff were expected to wear PPE when providing care to residents in Contact and Droplet isolation.

(ii) In May 2015, a PSW was observed serving snacks to residents in the hallway with gloves and gown donned after leaving another resident who was in Contact and Droplet isolation. The IPAC Lead and Administrator were interviewed and confirmed staff were expected to remove their PPE and perform hand hygiene before continuing to serve snacks to other residents in the hallway.

(iii) In May 2015, an RN was observed standing against the wall inside a resident's room who was identified as being in Contact and Droplet isolation. The RN had her PPE incorrectly donned. The RNs facial mask was improperly placed. The IPAC Lead and the Administrator confirmed that staff were expected to wear their PPE appropriately and were trained annually in proper donning techniques for PPE.

B) In May 2015, during the initial tour of the home, the LTC Inspector observed unlabelled nail clippers in the two tub rooms. The PSWs were interviewed and confirmed the nail clippers in both tub rooms were unlabelled and they were expected to be labelled. [s. 229. (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 all staff participate in the implementation of the program, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted: 8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

A) During Stage 1 of the Resident Quality Inspection (RQI) in May 2015, the LTC Inspector observed the door of a tub room open and shower curtains partially drawn. Resident #047 was in the bath tub with no staff in attendance and their privacy was breached. The PSW was observed standing across from the tub room entering resident care information into POC using the computer on the wall. The PSW was interviewed and identified that while watching the resident in the bath tub, the PSW was entering resident information into POC. The PSW confirmed that they were expected to provide privacy to residents when providing care and the resident should not be left unattended in the bath tub. The registered staff confirmed that residents were to be provided with privacy when care or treatment was being provided, and residents were not to be left alone in the bath tub. (527)

B) During the observation of the medication pass in May 2015,a registered staff member administered a medication subcutaneously to resident #016 while in the hallway. There were few residents sitting in the hallway at the time of administration. The RPN identified that they would have taken the resident to a more private space if the medication was being administered in another part of the resident's body, but because of where she was injecting the medication, it was not an issue. The plan of care was reviewed and it did not include the resident's preferences. The resident was interviewed by LTC Inspector #527 and the resident confirmed their preferences for privacy when treatment and care was being provided by staff. The DOC confirmed that it was an expectation that medication being administered by injection was administered in a space that promotes privacy for the resident. (561) [s. 3. (1) 8.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's toothbrush was labelled. Resident #040 stated their toothbrush was missing in May 2015. Later in May 2015, an unlabelled used toothbrush was noted in the wastebasket in the resident's washroom. The washroom was a shared space. The resident and a PSW providing care to the resident were unable to identify who the toothbrush belonged to. [s. 37. (1) (a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (2) The licensee shall ensure that each menu,
(b) provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time. O. Reg. 79/10, s. 71 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each menu provided for a variety of foods.

The Fall/Winter 2014-2015 snack menu included cookies on seven of seven days for all afternoon snack passes for all four weeks of the menu.

Sandwiches were served on five of seven evenings each week (except Week 3 had sandwiches served four of seven evenings) with the same type of sandwiches repeated throughout the menu cycle at the lunch meal. Some examples: Week 1 Tuesday - turkey served at lunch and turkey salad at the evening snack; Cheese sandwich served Wednesday lunch and again the evening snack on Thursday; Ham sandwich served Monday lunch, Thursday lunch and Friday evening.

The same desserts were repeated throughout the four week menu cycle with the same types of canned fruits being served multiple times each week and repeated throughout the weeks.

Documentation did not reflect that the lack of variety in the snack menu and desserts was a preference requested by the residents. [s. 71. (2) (b)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incident in the home no later than one business day after occurrence of the incident, followed by the report required under subsection (4),
3. A missing or unaccounted for controlled substance.

Resident #044 went on a LOA with their family in April 2015, and returned to the home three days later. A medication card with tablets was sent with resident and their family. When the resident returned to the home the family member did not return the medication card.

The clinical record identified that the police and the Ministry of Health and Long Term Care were notified in April 2015 of the incident.

The policy for "High Risk Medication - Opioid Analgesics", revised October 2013, identified that "missing and or misappropriated medications, including narcotics shall be reported immediately to the Administrator of the Home, Ministry of Health and Long Term Care, police and the contracted pharmacy vendor".

The Administrator confirmed that the critical incident was reported late to the Director. [s. 107. (3) 3.]

Issued on this 23rd day of July, 2015

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

Original report signed by the inspector.