Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Apr 20, 2015	2015_330573_0011	O-001786-15	Resident Quality Inspection

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

BALLYCLIFFE LODGE NURSING HOME
70 STATION STREET AJAX ON L1S 1R9

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

ANANDRAJ NATARAJAN (573), KARYN WOOD (601), LYNDA BROWN (111), MARIA FRANCIS-ALLEN (552)

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): April 7, 8, 9, 10, 13, 14, 15 and 16 2015.

Complaint Log O-000462-14 was inspected concurrently with the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, President of the Resident's Council, President of the Family Council, several personal support workers (PSWs), housekeeping aides, several Dietary Aides, the maintenance personnel, several Registered Practical Nurses (RPNs), the physiotherapist, Registered Nurses (RNs), the Program Support Service Manager, the Environmental Service Manager, the Nutritional Services Manager, the Corporate Nursing Consultant, the Director of Care and the Administrator.

During the course of the inspection, the inspector(s) conducted a tour of the Resident care areas, reviewed Resident's health care records, Manufacturer's Instructions (Air Mattress), home policies and procedures, Staffing schedules, staff work routines, reviewed the Admission process and Quality Improvement system, reviewed Residents and Family Council minutes. Inspectors observed Resident rooms, Resident common areas, observed a medication pass, observed meal service, and observed the delivery of Resident care and services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **6 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. (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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s.6 (1) (c) where by a Resident #08's plan of care related to personal hygiene/oral hygiene does not set out clear directions to staff and others who provide direct care to the resident.

Resident #08 was interviewed and reported that his/her teeth were only brushed once a month and he/she could not recall the last time his/her teeth were brushed.

A review of Resident #08's current care plan indicates that Resident #08 has hand tremors, and requires assistance with personal hygiene/oral hygiene. The resident's current care plan does not provide direction to staff in regards to Resident #08's oral hygiene.

Record review of Resident #08 documentation on specific days for a month period related to personal hygiene/oral care completed by PSW S#119 indicated that Resident #08 required full staff performance.

In an interview, PSW S#119 indicated that Resident #08 was able to brush his/her teeth

and only required set up assistance from staff. PSW S#119 also indicated that oral hygiene was provided before she went home.

In an interview with PSW S#104, PSW S#118 and RN S#105 indicated that Resident #08 has hand tremors and would require staff to brush his/her teeth.

Therefore, there was no clear direction to when and by whom the oral hygiene was to be provided to Resident #08. [s. 6. (1) (c)]

2. The licensee has failed to comply with LTCHA 2007, s.6 (1) (c) where by a Resident #43's plan of care related to use of side rails does not set out clear directions to staff and others who provide direct care to the resident.

Resident #43 has been identified as a high risk for falls. A review of Resident #43's current care plan indicates that Resident #43 has one ¾ bed rail raised as a PASD, and the intervention indicates to ensure the one ¾ bed rail is raised for safety and repositioning at all times.

On a specific day and time inspector observed Resident #43 to have one ¾ side rail raised. Resident #43 had signage on the wall just above the bed and the photo indicated that two ¾ bed rails were to be raised and were being used as a PASD.

In an interview with Resident #43's SDM indicated that Resident #43 used to have two side rails raised, but now only has one side rail raised because the resident was attempting to climb over the side rail.

In an interview with PSW S#107, RPN S#108, and the Director of Care indicated Resident #43 is a high risk for falls and should only have one ¾ side rail raised, is not aware of limitations, and would climb over the side rail. The signage located on the wall above Resident #43's bed related to side rail use was part of Resident #43's plan of care, and was no longer accurate.

Therefore, there was no clear direction regarding the number of side rails to be raised for Resident #43. [s. 6. (1) (c)]

3. The licensee has failed to comply with LTCHA 2007, s.6(7) where by the care set out in a Resident #43's written plan of care related to falls was not provided to the resident as specified.

Resident #43 has multiple history of falls since admission. A review of Resident #43's current care plan indicates that Resident #43 is high risk for falls and the interventions in place for Resident #43 is to ensure Resident #43 is wearing hip protectors as a safety device.

During observation of Resident #43 on two specific days it was identified that resident was not wearing hip protectors.

In an interview with Resident #43's SDM indicated Resident #43 wears the hip protectors due to a history of falls, and risk for fractures.

In an interview with PSW S#107, RPN S#108 both indicated Resident #43 is at high risk for falls, and should be wearing hip protectors.

On April 14, 2015 in an interview with the Director of Care indicated that the home's expectation of the PSW staff members is to apply hip protectors for Resident #43 as specified in the plan of care. [s. 6. (7)]

4. The licensee has failed to ensure that if the Resident #24 is being reassessed and the plan of care is being revised because care set in the plan has not been effective, that different approaches had been considered in the revision of the plan of care.

The progress notes of Resident #24 (during a two month period) indicated:
-On a specific day and time, the resident was complaining of pain to a specified area and was repositioned and given analgesics with poor effect.
- The following day a physician's order was received for an x-ray and increased analgesics. There was no indication the POA was notified of change in condition.
- 3 days later the x-ray was completed and later that day, a PSW reported "resident nasally congested".
- 4 days later the resident continued to complain of pain to a specified area and was given analgesic as ordered "with no effect as pt. continued to c/o soreness all night". The resident was also noted to have occasional wheezy, congested cough, and "will have MD re-assess resident this morning". Later that day, the resident complained of heartburn and was given a sublingual anti-angina medication. After 5 minutes the "resident remained not stable" and a second anti-angina medication was given. 5 minutes later, the resident stated "feeling much better". Later the same day, the resident continued to have "a hoarse cough, no wheezing or shortness of breath". The resident was having

poor intake and placed on respiratory isolation as a precaution and staff indicated “if symptoms worsen to contact MD". There was no indication the POA was notified of change in condition.
- 5 days later the resident had remained in bed, and continued to eat and drink poorly at both meals. Later the same day, the resident complained “of severe pain” to a specified area that was described as “sharp, stabbing, shooting pain that radiates”. Analgesic was given with little effect.
- 6 days later the resident continued to have a “hoarse, congested cough”. The physician was contacted and notified of respiratory condition and new order received for an antibiotic. The resident remained on bed rest and in isolation. Later the same day, the resident began vomiting and their respiratory condition deteriorated. The physician was contacted again and requested transfer to hospital for further assessment. The POA was notified the resident was transferred to hospital. The resident was admitted to hospital with a serious cardiac event.

Review of care plan for Resident #24 (in place at that time and current) indicated:
-Resident has identified pain, complains of pain less than daily. Interventions included: administer pain medications as per MD orders and staff to initiate 7 day pain flow sheet if intensity or frequency changes. There was no indication of location of pain or any revision/interventions in the care plan related to new diagnosis of serious cardiac event.

Therefore, when the Resident #24's condition changed (deteriorated) different approaches were not considered until 4 days later. [s. 6. (11) (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 by ensuring that:
- the plan of care for Resident #08 sets out clear directions to staff and others who provided direct care to the resident related to oral care.
- the plan of care for Resident #43 sets out clear directions to staff and others who provided direct care to the resident related to number of side rails to be used for Resident #43.
- the care set out in the plan of care is provided to the Resident #43 as it relates to the use of hip protectors.
- if the Resident #24 is being reassessed and the plan of care is being revised because care set in the plan has not been effective, that different approaches were considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The Licensee failed to comply with section 15(2) (a) of the Act in that the Licensee failed to ensure the home, furnishings, and equipment are kept clean and sanitary.

On April 8, 2015, during Stage 1 of the RQI, it was observed by Inspector #573 that Resident #17's wheelchair frame, wheels and cushion were heavily soiled and stained with dark brown color debris resembling dried food. It was also observed that Resident

#40's and #044's wheelchair had dried food debris and food stains on the lower metal frame, brakes, cushion seat and wheels. Inspector #111 observed Resident #13's walker with soiled black foam seat.

On April 14, 2015, during an interview with RPN S#101 who indicated to Inspector #573 that it is the responsibility of the PSW Staff members on night to clean resident wheelchairs and walkers.

On April 14, 2015, Inspector #573 spoke with Director of Care who stated that every resident wheelchair is cleaned on regular basis by the night PSW Staff members as outlined in the cleaning schedule. The Director of Care also indicated that resident wheelchairs are to be cleaned by the PSW Staff members whenever they are observed to be unclean or dirty. The Inspector observed the three identified wheelchairs noted above for Residents #17, #40, #44 in the presence of the Director of Care who agreed that the wheelchairs were unclean and further indicated that they should be kept clean. [s. 15. (2) (a)]

2. The licensee failed to ensure that, the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following areas of the home were observed in disrepair from April 7-9, 2015:

In an identified resident washroom: drywall behind newer toilet left unpainted.
In an identified resident washroom: stains noted around the base of the toilet and area behind new toilet was left unpainted.
In an identified resident washroom: drywall behind newer toilet left unpainted and two stained ceiling tiles.
In an identified resident washroom: floor tiles under sink have large water stains and no caulking around base of toilet.
In an identified resident washroom: quarter inch gap between small floor tiles in bathtub area and large floor tiles in sink area(rendering difficult to clean) and has slight change in elevation (causing potential tripping hazard), missing caulking around base of toilet, and lower half of bathroom door is heavily scuffed exposing raw wood. The plug receptacle was left exposed with no cover (The administrator was notified and repaired immediately).
In an identified resident washroom: caulking missing around base of toilet, quarter inch gap between smaller tiles in tub area and larger tiles in sink area (rendering difficult to clean), large area of hard water stains in sink, grout missing on several tiles around bath

tub, and lower half of bathroom door has a large area that is exposing raw wood.
In an identified resident washroom: large area of water stains on drywall below sink area, small area of chipped off wood (exposing sharp edges) in front of sink ledge, and large area of drywall damage (approximately 3.5 feet) on wall outside of bathroom, elevated toilet has gaps of missing caulking around base and area behind toilet left unpainted, and lower quarter of bathroom door is heavily scuffed exposing raw wood.
In an identified resident washroom: areas surrounding light switch has missing drywall and base of toilet has no caulking.
In an identified resident room: several holes in drywall in bathroom below grab bar, holes left unrepaired and unpainted to drywall where previous over bed light fixture was replaced (closest to window).
In an identified resident room: no caulking around base of toilet and large areas of damaged drywall at base of wall in bathroom.
In an identified resident room: large area of damaged drywall just outside bathroom.
In an identified resident room: drywall cracked and unrepaired above bed area (close to window),bathroom wall has drywall damage and black stains on ceiling tile, and counter top surrounding sink and ledge is damaged.
In an identified resident room: chipped drywall on lower portion of corner exposing metal, exposure of white metal between overhead lighting, and baseboard strip in bathroom is separated from the wall.
In an identified resident room: bathroom wall has drywall damage and stained floor tiles, and toilet base missing caulking. The telephone jack was missing the covering exposing wires (the Administrator was notified and area was immediately repaired).
In an identified resident washroom: toilet base missing caulking.
In an identified resident washroom: lower half of bedside wall has drywall damage and scuff marks, stained floor tiles under sink, and caulking missing around base of toilet.
In an identified resident washroom: sink in bathroom missing caulking surrounding the sink, and laminate at bottom of front skirt to sink not glued in place, and cracks to laminate surrounding the sink.
In an identified resident room: bathroom drywall has large scraped areas and one inch hole unrepaired, three inches of ceiling water damage and chipped drywall.
-4 floor tiles missing pieces of tile in hallway on first floor [s. 15. (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 1) the resident wheelchairs and walkers are kept clean and 2) the home is maintained in a safe condition and in a good state of repair, specifically related to wall surfaces and flooring in the identified areas, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturer's instructions.

Review of 5 identified resident beds indicated that the home had a therapeutic air mattress in place:

-Resident #02 had a specified therapeutic air mattress (A) which was set to a specified level and appeared under inflated.
-Resident #24 had a specified therapeutic air mattress (B) which was set to a specified level and appeared overinflated.
-Resident #46 had a specified therapeutic air mattress (C) which was set to a specified level and appeared over inflated.
-Resident #47 had a specified therapeutic air mattress which had a note indicating the system was set to the required level setting but not at the appropriate frequency.
-Resident #48 had a specified therapeutic air mattress (A) which was set to a specified level and appeared overinflated.

Interview of RPN S#108, S#116 and RN S#105 were unaware of what setting levels the identified resident's therapeutic air mattresses were to be set at (except for Resident

#47) and indicated the information would be located in the resident's health record. Review of the health record for Resident #02, #24, #46 & #48 had no indication of what setting level the therapeutic air mattresses were to be set at.

Interview of Director of Care (DOC) indicated she was unaware of what settings the therapeutic air mattresses were to be set at and indicated they should be indicated in the resident's health record. The DOC indicated the home only had the manufacturer`s instructions (on site) for specified therapeutic air mattress (A) and were located in the nursing office. The DOC was able to locate the manufacturer's instructions for the other therapeutic air mattress online.

Review of the manufacturer's instructions for a specified therapeutic air mattress (A) indicated the setting level was dependent on the resident's weight. Review of the health record for Resident #2 indicated the resident was currently exhibiting an alteration in skin integrity and the resident's air mattress was under-inflated. Review of the health record for Resident #48 indicated high risk for skin breakdown and based on the resident's weight, the resident's air mattress was overinflated.

Review of the manufacturers' instructions for a specified therapeutic air mattress (B) indicated to use the weight chart as a guideline but ensure you do a "hand check" and make sure the setting isn't too high (which would cause pressure) or too low (resident is bottoming out). Review of Resident #24 health records indicated the resident is at high risk for skin breakdown, currently has altered skin integrity, and based on the residents weight, the resident's air mattress was overinflated.

Review of the manufacturer's instructions for the a specified therapeutic air mattress (C) indicated for a 36 inch wide air mattress, a specified setting was to be used depending on the weight of the resident. Review of the health care record for Resident #24 indicated a high risk for skin breakdown and based on the resident's weight, the air mattress was overinflated. [s. 23.]

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 staff use therapeutic air mattress in accordance with manufacturer's instructions, to be implemented voluntarily.

WN #4: 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 comply with LTCHA ,2007,S.O. 2007, c.8, s 57 (2) in that the licensee did not respond in writing within 10 days of receiving a concern or recommendation to the Resident's Council.

The President of Resident's Council indicated during an interview with Inspector #573 that the Council does not receive any written response within 10 days from the Licensee regarding any advice or concerns made by the Council. The President of the Resident's Council further indicated that the concerns were addressed in the next or subsequent Council meeting.

Inspector #573 reviewed the Resident's Council meeting minutes for the month of January and February 2015. The Resident's Council meeting minutes of February 18, 2015 identified few concerns from residents regarding Windows in the resident rooms and concerns regarding need for better process in using elevators at the meal time. The written response was given to the President of Resident's council on March 18, 2015.

The Program Support Service Manager who does the assistant Duties for the Resident's Council stated to Inspector #573 that while the home address the concerns and recommendations within 10 days it is usually communicated and respond to the Resident's Council in the next subsequent council meeting. She further stated that for the concerns on February 18, 2015 Resident's Council meeting the written response was not provided within 10 days to the Resident's 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 the Licensee responds to the concerns or recommendations made by the Resident's Council in writing within 10 days, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 78. Food service workers, training and qualificationsTraining and qualifications

Specifically failed to comply with the following:

s. 78. (3) The licensee shall ensure that food service workers who were employed at the home before July 1, 2010, and who do not have the qualifications required under subsection (1), complete a food handler training program on or before October 1, 2010, unless they meet the requirements under subsection (1) sooner.

Findings/Faits saillants :

1. The licensee has failed to ensure that food service workers who were employed at the home before July 1, 2010 and who do not have the qualification required under subsection (1), complete a food handler training program.

In an interview, Food Service Manager (FSM) indicated that Dietary Aide S#113 & S#114 were hired before July 1, 2010 and had no records on file of ever completing the food handler training program but were each given a letter recently indicating they were required to have a completed food handler training program.[Log O-000462-14] [s. 78. (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 Dietary Aide S#113 and S#114 to complete a food handler training program as per the legislative requirements, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of maintenance services, the licensee ensured that there were schedules and procedures in place for routine, preventative and remedial maintenance.

Interview of Environmental Service Manager (ESM) indicated that he works full time and also has a full time maintenance person. The ESM indicated he has schedules (Maintenance Audit Resident Rooms, Environmental Deficiency Log, and Maintenance Request Log) to ensure that areas in the home are maintained in good state of repair. The ESM indicated that common areas are audited monthly and each resident room is audited a minimum of quarterly, to check for disrepairs. The ESM indicated that the Maintenance audit resident room checklist is not completed but any areas of disrepair are noted on the "Environmental Deficiency Log". These repairs are then to be completed by the maintenance person under the corrective action and date completed. The ESM indicated the home has a painting schedule but no painting had been completed in 2015 or scheduled as the maintenance focus was on replacing outdated toilets, sinks and faucets. The ESM indicated there is also a maintenance log book located at each nursing station for any staff to enter any maintenance concerns. The ESM indicated several toilets were replaced (greater than five years ago) and placed on elevated square platforms that was shorter than the rounded toilet base rendering it difficult to caulk, and resulted in the areas behind the toilets unpainted. The ESM was unable to provide any written procedures for routine, preventative and remedial maintenance related to disrepairs in the homes and what schedules are to be used and when.

Interview of the maintenance person indicated he reviews the maintenance request logs at each nursing station daily (when he first arrives in the morning) and completes those repairs/requests first. The maintenance person indicated he then completes the maintenance on the "Environmental Deficiency Logs" for the remainder of the day. The maintenance person indicated he was just starting to complete the environmental deficiency logs dated September 2014 and was just provided the first quarter deficiency logs by the ESM. The maintenance person indicated that a contractor comes in to complete any drywall/painting repairs.

Review of "Environmental Deficiency Logs" (dated, January, February, March 2015) indicated dis-repairs to several rooms and all disrepair areas were all blank under "corrective action" and "date completed". Several of the identified areas of disrepairs

noted by the inspectors were not identified. The room audit checklists were also not completed (which would indicate that all rooms were audited for any disrepairs). Review of the maintenance request logs did not indicate any of the disrepairs noted by the inspectors.

Interview of the Administrator stated "the corporate office just provided me with a "Maintenance Inspection Checklist" that was to be used to complete the resident/common areas audits" but the checklist only indicated what was to be inspected but not the frequency of the inspection or what other schedules were to be used. The ESM was not aware of this checklist. The Administrator also provided a copy of a "painting schedule 2014" that indicated which rooms were actually painted last year. The Administrator indicated that the maintenance audit resident room schedule should have been completed to indicate which resident rooms were actually inspected and when. [s. 90. (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 there were schedules and procedures in place for routine, preventative and remedial maintenance of the home, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Resident Admission package does not include the following information:

-an explanation of the duty under section 24 of the LTCHA, Reporting Certain Matters to the Director, to make mandatory reports [section 78(2)(d)]

-a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents [section 78(2)(n)]

On April 14, 2015, Inspector #573 reviewed the admission package with the home's Administrator and confirmed that the admission package does not include the legislative requirements listed above. [s. 78. (2)]

WN #8: 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 controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area with the locked medication cart.

Interview of RPN S#116 indicated that the controlled substance in the home (injectable ativan) is kept in the medication room fridge.

Review of the medication room on second floor indicated the controlled substance (2 boxes of injectable ativan) were located in an unlocked fridge in a locked medication room. [s. 129. (1) (b)]

Issued on this 21st day of April, 2015

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

Original report signed by the inspector.