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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 18, 2014	2014_259520_0026	L-001189-14	Resident Quality Inspection

Licensee/Titulaire de permis

MACGOWAN NURSING HOMES LTD
719 Josephine Street, P.O. Box 1060, WINGHAM, ON, N0G-2W0

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

BRAEMAR RETIREMENT CENTRE
719 Josephine Street North, R.R. #1, P.O. Box 1060, WINGHAM, ON, N0G-2W0

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

SALLY ASHBY (520), CHRISTINE MCCARTHY (588), JUNE OSBORN (105), RUTHANNE LOBB (514)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 3,4,5,8,9,10 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, 4 Registered Nurses, 5 Registered Practical Nurses, Environmental Services Manager, Nutrition Manager, Physiotherapist, 6 Personal Support Workers, 2 Housekeeping/Laundry Aides, Dietary Aide, Business Manager, Activation Aide, 3 Family Members and 40 Residents.

During the course of the inspection, the inspector(s) observed residents and staff, toured resident home areas, conducted resident/family/staff interviews, reviewed resident's clinical records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care
Training and Orientation

Findings of Non-Compliance were found during this inspection.

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).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident as evidenced by:

A review of a Resident's Care Plan showed a discrepancy between the Care Plan, Physician's Orders and Nurse's Notes.

An interview with the Director of Nursing verified the discrepancy between the Physician's orders and the plan of care. The Director of Nursing stated the expectation of the Home was to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident [s. 6. (1) (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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: 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:
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 non-residential areas 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, as evidenced by:

On a date in September 2014 during a tour with the Director of Care a laundry room was found unlocked and unattended.

The Director of Care verified that the door should be locked when unattended as there were chemicals inside. The expectation of the home was to ensure 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. [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 that all doors leading to non-residential areas 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 #3: 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 ensure that the home, furnishings and equipment are

maintained in a safe condition and in a good state of repair as evidenced by:

Audit completed on a date in September 2014 revealed the following maintenance concerns:

Room A – Drywall damage and paint chipped x 2 areas on bedroom wall near bathroom door, paint chipped on bathroom door frame and inner bathroom door.

Room B – Drywall damage on corner wall near bathroom door, missing baseboard on one bathroom wall.

Room C – Paint chipped on bedroom door frame, drywall and baseboard damage to corners of bedroom wall near bathroom door, paint chipped on bathroom door frame and inner bathroom door.

Room D – Paint chipped on bedroom door frame and door.

Room E- Drywall damage on corner wall near bathroom door, dim lighting in bathroom.

Room F - Drywall damage and paint chipped x 2 areas on bedroom wall near bathroom door, paint chipped on bathroom door frame and inner bathroom door.

Room G – Wall damage in bathroom beside soap dispenser.

Room H - Paint chipped on bathroom door frame and inner bathroom door.

Room I – Significant paint chipping on inner bathroom door and bathroom door frame. Paint chipped and wall damage beside bathroom door.

Room J – Drywall damage on corner wall near bathroom door.

Room K – Paint chipped along length of bathroom wall, and on bathroom door frame and inner bathroom door.

Room L – Dim lighting in bathroom, significant paint chipping on bathroom door frame.

Room M – Paint chipped on bedroom door frame, drywall damage and chipped paint x

2 areas on bedroom wall near bathroom door, paint chipped on bathroom door frame and inner bathroom door.

Room N – Paint chipped on bathroom door and bathroom door frame.

Room O - Drywall damage and paint chipped x 2 areas on bedroom wall near bathroom door, paint chipped on bathroom door frame and outer bathroom door.

Room P – Dim lighting in bathroom, paint chipped on bathroom door frame.

Room Q – Dim lighting in bathroom, dark areas between floor tiles, chipped floor tile around floor drain in bathroom, paint chipped along length of bathroom wall.

Room R – Dim lighting in bathroom, paint chipped on bathroom walls, drywall damage and paint chipped x 2 areas on bedroom wall near bathroom door, paint chipped on bathroom door frame and inner bathroom door.

Room S – Dim lighting in bathroom, paint chipped on bathroom door frame and inner bathroom door, drywall damage and paint chipped on two corners of the bedroom walls, chipped corner on bedroom door frame.

Room T - Paint chipped on bathroom door frame and inner bathroom door, paint chipped along bathroom walls.

Room U – Chipped corner on bedroom door frame x 2, paint chipped on bathroom door frame and inner bathroom door, 6x6 cm hole in the linoleum flooring in bathroom, paint chipped around bathroom sink, drywall damage along bathroom wall.

Room V – Chipped corner on bedroom door frame, drywall damage and paint chipped x 2 areas on bedroom wall near bathroom door, paint chipped on bathroom door frame and inner bathroom door, significant drywall damage and paint chipped on bathroom walls.

Room W - Paint chipped on bathroom door frame and inner bathroom door, paint chipped on bathroom walls.

Room X – Paint chipped on bathroom door frame and on bathroom walls.

Room Y – Paint chipped on bedroom door frame, paint chipped around bathroom sink, 3 holes in linoleum flooring in bathroom (4x6 cm, 1x1 cm, 1x1 cm), paint chipped around bathroom sink and soap dispenser, baseboard and wall damage on corner walls on either side of bathroom door, paint chipped on bedroom wall.

Room Z – Baseboard pulling away on wall outside bedroom, baseboard and wall damage on corner of bedroom wall, significant paint chipping on bathroom walls, paint chipped on bathroom door frame and inner bathroom door, paint scraped along lower closet doors, paint chipping on bedroom wall near closet.

Room AA – Wall damage at corner guard in bedroom, wall damage and paint chipping on bedroom wall, paint chipped on bathroom door frame.

Room BB – Paint chipped on bathroom door frame.

Room CC – Dim lighting in bathroom, paint chipped on bathroom door frame and inner bathroom door.

Room DD – Wall damage and baseboard piece missing on corner wall near bathroom door, paint chipping on bathroom door frame.

The above noted maintenance concerns were verified by the Environmental Services Manager. [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 the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails are used, (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment as evidenced by:

A room audit completed on a date in September 2014 revealed three beds to have entrapment concerns. These beds were verified by the Director of Care as having entrapment concerns.

A review of the Bed Assessment completed by Cardinal Health Canada on May 28, 2014 for the LTCH revealed that these same beds had failed various zones (Report was received by the home August 2014).

The Director of Care stated the expectation of the home was to eliminate all potential zones of entrapment for Residents. [s. 15. (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 where bed rails are used, (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to ensure that every window in the home that opens to the outdoors and is accessible to Residents has a screen and cannot be opened more than 15cm as evidenced by:

An Audit completed on a date in September 2014 noted that six windows that opened to the outside opened more than 15cm. The window openings were verified by the Director of Care as opening more than 15cm.

In addition, both windows in a common area which opens to the outdoors opened more than 15cm. This was verified by the Environmental Services Manager who measured the openings. [s. 16.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that, (e) is available in every area accessible by residents; as evidenced by:

Observation of the Lounge across from the Nurses Station revealed there was no communication and response system (call bell) in place.

The Director of Care and the Environmental Services Manager confirmed there was no call system in the Lounge, and acknowledged a call system was required.

During a tour of the home on a date in September 2014 it was noted that there was not a resident-staff communication and response system (call bell) in the small dining room. This was verified by employees from both environmental and recreation departments who confirmed the absence of a call bell. [s. 17. (1) (e)]

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 is equipped with a resident-staff communication and response system that is available in every area accessible by residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a care conference of the interdisciplinary team providing a resident's care is held at least annually to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker as evidenced by:

During a review of a Residents' clinical records it was noted that the last annual care conference was over a year ago.

The Director of Care verified that the annual conference had not been held within the year and that it was overdue. [s. 27. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a care conference of the interdisciplinary team providing a resident's care is held at least annually to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

s. 76. (6) Every licensee of a long-term care home shall ensure that the following are done:
1. The further training needed by the persons mentioned in subsection (1) is assessed regularly in accordance with the requirements provided for in the regulations. 2007, c. 8, s. 76. (6).
2. The further training needs identified by the assessments are addressed in accordance with the requirements provided for in the regulations. 2007, c. 8, s. 76. (6).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff have received retraining annually relating to the following:
* The Residents' Bill of Rights
* The long-term care home's mission statement
* The home's policy to promote zero tolerance of abuse and neglect of residents
* The duty to make mandatory reports under section 24
* The whistle-blowing protections
* The home's policy to minimize the restraining of residents

* Fire prevention and safety
* Emergency and evacuation procedures
* Infection prevention and control
* All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that are relevant to the staff member's responsibilities, as evidenced by:

On a date in September 2014, a review of the training records revealed that all staff had not been retrained annually in the mandatory training requirements. The home was able to provide a number of incomplete education tracking sheets and binders but were unable to determine numbers of staff that completed mandatory training and numbers of staff who did not complete mandatory training.

The Administrator verified that the home had not completed the required mandatory training for 2013 and 2014 for all staff. The Administrator confirmed that the home was in the process of changing their education program to ensure compliance with the mandatory education requirements. [s. 76. (4)]

2. The licensee failed to ensure that all staff training needs are assessed at least annually as evidenced by:

On a date in September 2014, interviews with the Administrator and Director of Nursing revealed that the home had not assessed the training needs for all staff at least annually in 2013 or 2014. [s. 76. (6) 1.]

3. The licensee has failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7), as evidenced by:

On a date in September 2014, a review of the training records revealed that direct

care staff had not been retrained annually in the mandatory training requirements. The home was able to provide a number of incomplete education tracking sheets and binders, but were unable to determine numbers of direct care staff that completed mandatory training and numbers of direct care staff who did not complete mandatory training.

The Administrator verified that the home had not completed the required mandatory training for 2013 and 2014 for direct care staff. The Administrator confirmed that the home was in the process of changing their education program to ensure compliance with the mandatory education requirements. [s. 76. (7)]

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 have received retraining annually relating to the following:

**** The Residents' Bill of Rights***
**** The long-term care home's mission statement***
**** The home's policy to promote zero tolerance of abuse and neglect of residents***
**** The duty to make mandatory reports under section 24***
**** The whistle-blowing protections***
**** The home's policy to minimize the restraining of residents***
**** Fire prevention and safety***
**** Emergency and evacuation procedures***
**** Infection prevention and control***
**** All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that are relevant to the staff member's responsibilities. Also to ensure that all staff training needs are assessed at least annually, to be implemented voluntarily.***

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

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, as evidenced by:

On a date in September 2014 in the Blue Lagoon Tub room a bottle of Arjo tub disinfectant was found on the floor beside the tub .

This was verified by a Registered Practical Nurse who removed the disinfectant immediately.

On a second date in September 2014, Arjo tub disinfectant was discovered again in the Blue Lagoon Spa on the floor beside the tub.

The Director of Care verified the presence of the disinfectant and immediately removed it. She acknowledged the disinfectant should be secured and inaccessible to the residents.

The Environmental Services Manager shared that staff were to keep the tub disinfectant stored in the locked utility room when not in use.

The cabinets in all tub rooms were provided with a lock on that second date to secure hazardous substances and keep them inaccessible to the residents. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area; as evidenced by :

Observation of the controlled substances for disposal in the medication room were noted to be in a locked container inside an unlocked cupboard.

This was verified by a Registered Practical Nurse.

The Director of Care confirmed the cupboard was not locked and locked the cupboard immediately. [s. 129. (1) (b)]

Additional Required Actions:

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

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that where a drug that is to be destroyed is not a controlled substance, it will be done by a team acting together and composed of:
i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
ii. one other staff member appointed by the Director of Nursing, as evidenced by;

Review of the Medication Destruction Record Form revealed that on three dates in 2014 only one Registered Practical Nurse signed for the destruction of medications that were not narcotics.

The Director of Care verified this finding and acknowledged there should be two staff destroying the medications and signing for them. [s. 136. (3) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where a drug that is to be destroyed is not a controlled substance, it will be done by a team acting together and composed of:
i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
ii. one other staff member appointed by the Director of Nursing, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (2) The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 216 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the training and orientation program is evaluated and updated at least annually in accordance with evidence based practices and, if there are none, in accordance with prevailing practices, as evidenced by:

On a date in September 2014, interviews with the Administrator and Director of Nursing revealed that the home had not evaluated the Training and Orientation program at least annually, in 2013 and 2014. [s. 216. (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 training and orientation program is evaluated and updated at least annually in accordance with evidence based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #13: 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 all staff participate in the implementation of the infection prevention and control program, as evidenced by:

The following unlabelled or improperly stored personal care items were observed in resident accessible bathrooms:

On a date in September 2014 in a Residents communal bathroom, an unlabelled comb and hair accessories were observed on the back of the toilet.

On a date in September 2014 in a Residents communal bathroom, unlabelled urine collection items were observed hanging from a rail in the Residents' bathroom.

These unlabelled items were verified by a registered staff member.

The Director of Nursing confirmed the expectation of the Home was to have all personal care items 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 infection prevention and control program, to be implemented voluntarily.

WN #14: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the following rights of residents are fully respected and promoted: Every resident has the right to have his or her personal health information kept confidential as evidenced by:

On a date in September 2014, an exposed, unattended and unlocked Medication computer screen which showed Personal Health Information was observed in the Green hallway/East wing. This was verified by a Registered Practical Nurse.

The Director of Nursing confirmed that the expectation of the Home was to ensure the Residents' Personal Health Information was kept confidential. [s. 3. (1) 11. iv.]

Issued on this 3rd day of October, 2014

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