



**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
Direction de l'amélioration de la
performance et de la conformité**

**Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670**

**Bureau régional de services d'Ottawa
347, rue Preston, 4^{ième} étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670**

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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
Feb 26, 2013	2013_193150_002	O-000092- 13	Resident Quality Inspection

Licensee/Titulaire de permis

**CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9**

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

**CARESSANT CARE BOURGET
2279 Laval Street, P.O. Box 99, Bourget, ON, K0A-1E0**

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

CAROLE BARIL (150), COLETTE ASSELIN (134), LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): February 6, 7, 11, 12, 13, 14, 19, 20 and 21, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Corporate Consultant, several Registered Nursing staff, several Personal Support Workers, Maintenance and Housekeeping staff, Physiotherapist Assistant, Physiotherapist, Dietary staff, Physician, several residents and family members.

During the course of the inspection, the inspector(s) reviewed residents' health records, observed several meal services, observed several residents' rooms and common areas, observed residents' furniture, observed residents' activities, reviewed the admission process, several of the home's policies and procedures and the Resident and Family Council minutes.

During this inspection two critical incident report were inspected related to abuse:

log #O-000040-13 (CI# 1160-000002-13, 1160-000003-12).

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control



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Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Trust Accounts

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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).

Findings/Faits saillants :



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1. The Licensee failed to comply with the LTCHA, S.O.2007, c.8, s.6 (1) (c), in that the plan of care does not provide clear direction to staff providing direct care as it relates to Resident #329, who is resistive to care and for Resident #341's toileting needs and responsive behaviours.

On February 7, 11,12, 13, 14, 19, 2013, Resident #329 was observed in bed in poor body alignment and wearing a blue hospital gown all of the day shifts. The resident was not groomed most days and mouth care was not done on one specific day. Due to resident's refusal to come to the dining room, breakfast and lunch trays were brought to the resident's room for all those days.

The plan of care was reviewed and there is an entry indicating resident requires, personal care and mouth care daily for maintenance of appearance related to cognitive impairment, refusal of care and poor judgment. Furthermore there is an entry indicating resident is to have all meals in second floor dining room.

Staff #S108 was interviewed and indicated that resident #329 normally refuses care by yelling "no stop this and get out of my room". Staff members will go back within a few minutes and if resident refuses again the resident is left in bed not groomed and not dressed.

As such, there are no clear direction to staff as it relates to interventions or approaches to be used to ensure Resident #329 is provided personal care daily even though resident is resistive to care.

Resident #341's plan of care instructs staff to take resident to the toilet every hour but resident is at times resistive to care. Staff interviewed indicated that if resident refuses to go to the toilet, they do not normally go back and will wait for the next hour. Staff #S108 indicated that hourly monitoring is often missed at meal and snack times, consequently the resident is incontinent on the floor in the hallway. [s. 6. (1) (c)]

2. The Licensee failed to comply with the LTCHA, 2007, S.O. 2007, c.8, s.6 (7) in that the care set out in the plan of care was not provided to Resident #360.

Resident #360 is at risk of falls and had two falls beside the bed in January 2013, where an injury to the coccyx was sustained.



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The current plan of care was reviewed and there is an entry specifying that the wheelchair is to be removed from the bedside to prevent the resident from getting out of bed without assistance and for the resident to use a soft cushion while sitting in the wheelchair.

On February 12, 14 and 20, 2013 the wheelchair was left at the bedside, while Resident #360 was in bed for a nap.

On February 7, 11, 12, 13, 14, 19, 20 and 21, 2013, Resident #360 was observed by Inspector #134, to be sitting in poor body alignment in a wheelchair which was not the appropriate size for the resident and was without a soft cushion. The resident was interviewed and reported pain and discomfort in the lower back. [s. 6. (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 the written individualized plan of care sets clear directions to staff who provide direct care to residents specifically to those with responsive behaviours, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 87.

Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :



1. The licensee has failed to comply with the O. Reg 79/10 s.87 (2) (d), in that it failed to address incidents of lingering urine offensive odours.

During the entire course of the inspection lingering offensive odours were noted upon entering the home.

There was offensive lingering odours observed in four identified rooms.

On February 11, 2013 at 13:30h, in one identified resident's room, the mattress was observed to be soiled with dried urine and had a strong offensive lingering odour. Staff #S118 was interviewed and reported that the mattress is disinfected with Virox and R2 products when resident is incontinent of urine in bed, however the staff indicated the odour persists.

On February 11, 2013 in the afternoon, in one identified resident's bathroom, offensive urine odour was present.

During the entire course of the inspection, the flooring in the bathroom of one identified bathroom was observed to be in poor repair and curled at the edges. Despite the routine cleaning the offensive odour persisted.

On February 7, 11, 12, 13, 14, and 19, 2013, in one identified bedroom, bed sheets were soiled and room was untidy. It was observed that resident's room had lingering offensive odour due to the resident's tendency of hiding soiled clothing under the mattress and in the drawers.

On February 21, 2013, Staff #S119 was interviewed and reported that nursing staff was responsible to wipe up residents' urine and food spillage; that an orange mop is available for nursing staff to use as needed, however staff #S112 was interviewed and reported that no mop is made available for nursing staff on the units; that liquid spillage or urine was wiped with towels and was not always disinfected during the evening or night shift. The utility rooms on the first and second floor were inspected on February 21, 2013 by Inspector #134 and there were no mop or cleaning supplies available to nursing staff. [s. 87. (2) (d)]



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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 the home addresses lingering offensive odours in a timely manner, to be implemented voluntarily.

WN #3: 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:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
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).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
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).

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

- i. the Residents' Council,
- ii. the Family Council,
- iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
- iv. staff members,
- v. government officials,
- vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).

19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).



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21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

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



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21. Every resident has the right to meet privately with his or her spouse or a not

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, S.O.2007, c.8, s.3. (1) 2. in that the licensee did not ensure that the following residents' rights were fully respected and promoted: the right to be protected from abuse as it relates to Resident #01 and Resident #329.

As reported per the Critical Incident Report of January 2013, Resident #01 reported to the Director of Care that staff #S114 was verbally and physically abusive when extra desert was requested.

As reported in the Critical Incident Report, in January 2013, an identified staff member reported that staff #S114 was rude and disrespectful toward Resident #329.

The home has applied disciplinary measures as it relates to these incidents. Staff and Administrator confirmed that education on abuse prevention and Residents' Bill of Rights, is provided on an ongoing basis. [s. 3. (1)]

2. The licensee failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.3 (1) (11) (iv) in that it failed to protect the personal health information of residents.

It was observed by Inspectors #150, #134, #126, between the 11th and 21st of February 2013, during the medication administration observation, that the empty multi-dose medication packages, which identify residents' personal health information including the names of the residents and their medications, were discarded in the regular garbage.

Staff #S101 and #S115 were interviewed and confirmed that the medication packages were discarded in the regular garbage which is picked-up by a private disposal company. [s. 3. (1) 11.]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 10. Recreational and social activities



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Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that there is an organized program of recreational and social activities for the home to meet the interests of the residents. 2007, c. 8, s. 10 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, c.8, S.O.2007 s.10. (1) in that the home does not have at this time an organized recreational and social activities program to meet the interests of the residents.

Between the period of February 6 and 21, 2013, during the course of the Resident Quality Inspection (RQI), a limited number of activities were observed. The home provided daily exercises done by the Assistant Physiotherapist as well one bingo and two masses.

On the first floor, several residents were observed to be sitting in the television room watching TV or sleeping. On the second floor, several residents were sitting at the nursing station listening to country music. When staff were interviewed, the Inspectors were informed that the home was in the process of hiring an Activity Coordinator. No leadership in program of recreational and social activities was observed.

The Administrator indicated that there was no Activity Coordinator in the home since the end of December 2012 and that an Activity Coordinator had been hired recently.

During the course of the inspection, the February monthly activity calendar was not observed by the Inspectors on either units.

On February 20, 2013, discussion was held with Staff #S104 and #S123, who indicated that the Activity Coordinator was hired last week, but have not met the new hire. Both indicated they were not aware that a February monthly activity calendar was available. [s. 10. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings



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Specifically failed to comply with the following:

s. 12. (2) The licensee shall ensure that,

(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care; O. Reg. 79/10, s. 12 (2).

(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).

(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).

(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).

(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).

(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s.12 (2) (e) in that the home does not provide a comfortable easy chair for every resident in the residents' bedroom.

On February 7, 2012, Resident #289 was observed sitting on the bed to watch TV. The resident stated there is not enough space to accommodate a comfortable easy chair. [s. 12. (2)]

2. Residents #291, #304, #341, #359, #360 had no comfortable easy chairs provided in their room. [s. 12. (2) (e)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service



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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:

1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The Licensee failed to comply with O.Reg 79/10 s.73 (1) 1, in that the weekly menu was not posted.

The inspectors observed that the weekly menu was not posted during the course of the inspection between February 6 and 21, 2013.

Staff #S101 and #S102 reported to Inspector #134 that they did not know if there was a weekly menu available on the units.

Staff #S105 reported to Inspector #134 that the weekly menu is not posted on the unit but is kept in the main kitchen. [s. 73. (1) 1.]

WN #7: 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).



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Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s.129. (1) (a) (iv), in that the home was noted to have expired medications in the storage room.

On February 14, 2013, Inspector #126 reviewed the Storage medication room (216) on the second floor. The following medications were noted to have expired dates: Novasen 325 mg, 6 bottles with an expiratory date of January, 2013 [s. 129. (1) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
 - i. persons who may dispense, prescribe or administer drugs in the home, and
 - ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :



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1. The licensee has failed to comply with O. Reg 79/10. s.130.1 in that the licensee does not ensure that all drugs are kept locked at all times.

On February 18, 2013 at 11:00, the treatment cart holding prescribed creams was observed to be unlocked in the clean utility room. All staff have access to the utility room. [s. 130. 1.]

2. The licensee has failed to comply with O. Reg 79/10. s.130.2, in that the licensee did not ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, as well as the Administrator.

The medication storage room (216) on the second floor has a stairwell that gives access to the roof.

On February 21, 2013, discussion was held with Maintenance Staff #S115, who indicated that a key is available for access to the medication storage room, on second floor, to allow delivery of nursing/medical supplies and to access the roof if necessary. [s. 130. 2.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes

Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :



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

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

1. The Licensee failed to comply with the O. Reg 79/10 s.134 (a) in that the licensee failed to monitor and document the resident's response to analgesics given PRN for back pain.

Resident #360 fell in January 2013 and sustained an injury to the coccyx and complained of pain.

Tylenol 500mg two caps is ordered three times a day as needed.

Tylenol 500 mg 2 caps were administered for back pain on several days in February 2013. There is no documentation indicating the resident's response and the effectiveness of the medication in the resident's health care record. [s. 134. (a)]

WN #10: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:

1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :



Ministry of Health and
Long-Term Care

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1. The licensee has failed to comply with O.Reg 79/10 s.229 (10)1 in that the home did not screen the identified residents for tuberculosis within 14 days of admission.

The following resident did not received the Step 1 Mantoux Tuberculosis (TB) testing within 14 days of admission:

Resident #368 was admitted in September 2012, TB testing was done 26 days post admission.

Resident #369 was admitted in September 2012, TB testing was done 23 days post admission.

Resident #360 was admitted in October 2012, TB testing was done 25 days post admission. [s. 229. (10) 1.]

Issued on this 27th day of February, 2013

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

A handwritten signature in cursive script that reads "Carol Burt".