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

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

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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
Apr 11, 2014	2014_229213_0021	L-000271-14	Resident Quality Inspection

Licensee/Titulaire de permis

~~DIVERSICARE VI LIMITED PARTNERSHIP~~ C/O Southbridge Management Services LP.
~~458 Glencairn Avenue, TORONTO, ON, M5N-1V7~~ 150 Water St. S. Suite 201 Cambridge, On N1R 3E2

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

CHELSEY PARK (OXFORD) NURSING HOME
310 OXFORD STREET WEST, LONDON, ON, N6H-4N6

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

RHONDA KUKOLY (213), CAROLEE MILLINER (144), JULIE LAMPMAN (522), MELANIE NORTHEY (563)

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): March 25, 26, 27, 28 & 31, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care, the Staff Education Manager, the Manager of Food Services, the Production Supervisor, the Maintenance Manager, a Maintenance Technician, the Recreation and Program Manager, the Infection Control Coordinator, 8 Registered Nurses, 5 Registered Practical Nurses, 3 Personal Support Workers, 1 Nursing Administration Clerk, 3 Dietary Aides, 21 Residents, and 4 Family Members.

During the course of the inspection, the inspector(s) conducted a tour of all Resident areas and common areas, observed Residents and the care provided to them. Observed meal and snack service, medication administration and medication storage. Clinical records for identified Residents were reviewed. The inspectors reviewed policies and procedures as well as minutes of meetings pertaining to the inspection, observed general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to the outside of the home, including balconies and terraces, are kept closed and locked, equipped with a door access control system that is kept on at all times, and is equipped with an audible door alarm that allows calls to be canceled only at the point of activation as evidenced by:
a) On March 25 and 28, 2014, on 2nd floor, the sliding door leading to an outside balcony was observed open approximately 10cm with a chain locked with a key on the top of the door preventing it from opening further. The Registered Nurse confirmed that the key controlled door alarm system had been placed on bypass.
b) On March 25 and 28, 2014, on 4th floor, the sliding door leading to an outside balcony was observed locked with a chain which was locked with a key on the top of the door, however, when opened by the nurse, there was no audible alarm heard that indicated the door had been opened. An identified staff member confirmed that the key controlled door alarm system was not functioning properly.
c) The Director of Resident Care confirmed that it is an expectation that all doors to balconies are kept closed and locked and the audible door alarm is on and functioning properly at all times. [s. 9. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 resident-staff communication and response system is available in every area accessible by residents as evidenced by:
a) There were no call bell pull stations observed in the dining rooms or the resident lounges on 2nd, 3rd, 4th or 5th floors. There were whistles tacked to the wall in every dining room with signs indicating "in case of emergency - use whistle"
b) The Administrator and the Director of Resident Care confirmed that there is no resident-staff communication and response system in the dining rooms or the resident lounges on all 4 resident care floors. [s. 17. (1) (e)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 :

1. The licensee failed to ensure that the area where Government stock medications and drugs for destruction are stored is restricted to persons who may dispense, prescribe or administer drugs in the home as evidenced by:

a) Interview by Inspector #213 with an identified staff member confirmed that this staff member holds the key to the Government stock medication storage room which also houses all drugs for destruction.

b) The identified staff member confirmed responsibility to manage the Government stock medications, seals the box with the discontinued medications when the bio-hazardous waste bag is full and marks it "RX" and the pharmacy comes to pick up the box for destruction.

c) The Nursing Administration Clerk and the Director of Resident Care confirmed that the staff member with the responsibility to manage the Government stock medications is not a registered nursing staff member. [s. 130. 2.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The Licensee failed to ensure the Resident was reassessed and the plan of care reviewed and revised when the Resident's care needs changed as evidenced by:
a) Chart review for a Resident revealed the Resident had a fall resulting in an injury, was transferred to hospital and returned to the home. The most recent pain assessment was completed prior to the fall with no other pain assessment completed since return from hospital. Progress notes written upon return from hospital described the Resident as having pain. The care plan was not updated to include interventions for pain management as identified in the progress notes. Staff interview with a Registered staff member, confirmed the care plan should include interventions to manage pain.
b) Chart review for a Resident revealed progress notes identified several new behaviours were exhibited. Staff interview with Registered staff member confirmed the care plan should include goals and interventions to address responsive behaviours.
c) Chart review for a Resident revealed this Resident had a wound and a wound assessment was not completed. The last wound assessment documented was dated 5 months prior. Staff interview with a Registered staff member confirmed a wound assessment should have been completed. Staff interview with a Registered staff member confirmed there should be wound care goals and interventions for the wound and they were missing from the skin integrity section of the care plan for this Resident.
[s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that Residents are reassessed and plans of care are reviewed and revised when Residents' care needs change, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The home failed to ensure that the Emergency Drug Box Policy number 11-12 was complied with as evidenced by:
a) The home's Emergency Drug Box Policy number 11-12 states the emergency drug box is to be kept locked at all times and is to be kept within the locked medication room.
b) During an observation of a medication room a Registered staff member demonstrated the location of the emergency drug supply. The emergency drug supply was stored in an unlocked steel box.
c) Interview with the Director of Care confirmed the expectation that the emergency drug supply box should be locked at all times. [s. 8. (1)]

2. The licensee failed to ensure that the Dietary Services Policy DIET-07-01-03 was complied with as evidenced by:
a) The Dietary Services Policy DIET-07-01-03 includes directions for staff to take and record food temperatures before serving each meal to ensure hot and cold foods are served to residents at the appropriate temperature.
b) March 9, 2014, food temperatures were not recorded for the third floor second seating supper meal.
c) March 15, 2014, food temperatures were not recorded for the third floor second seating lunch meal.
d) March 23, 2014, food temperatures were not recorded for the third floor lunch and supper meals.
e) There were no recorded food temperatures available for breakfast, lunch and supper on the fourth floor for March 1, 2, 4 and 5, 2014.
f) March 10, 2014, food temperatures were not recorded for the fourth floor second seating supper meal.
g) There were no recorded food temperatures available for breakfast, lunch and dinner on the fifth floor from March 1 to 15, inclusive, 2014.
h) Two managers confirmed the home policy directs staff to record food temperatures before serving each meal. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system put in place is complied with, to be implemented voluntarily.

WN #6: 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 kept clean and sanitary as evidenced by:
a) Observation of 4th floor dining room on March 24, 2014 revealed all table stands were splattered with old food and fluids before the meal began, table #6 shifted from position revealing dark dirt rings observed on the floor and a small tear noted on vinyl seat situated a at table #7.
b) Observation of a bathroom on a particular date revealed a thin layer of feces smeared along counter at right side of the sink. Faint odour of feces detected in bathroom during observation. [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 as evidenced by:
a) The shower room ceiling on the 2 North Resident home area has a large and small hole. This was confirmed by one staff and Inspector #213.
b) The ceiling tracking adjacent to the television lounges on floors 2, 3, 4 and 5 are rusted. This was confirmed by one manager and Inspectors #522 and #563.
c) The surfaces of multiple Resident and service room entrance doors throughout the home are chipped. This was confirmed by one manager and Inspectors #213, #522 and #563.
d) One staff confirmed there are large scrapes on the outside of the elevator doors on the 4 South Resident home area.
e) Two managers and Inspectors #213, #522 and #563 confirmed there are multiple patched and or stained ceiling tiles, ceiling tiles that are ajar in the tracking and or have holes in them throughout the home.
f) Several wall surfaces in Resident rooms throughout the home are heavily scraped. This was confirmed by one manager and Inspectors #213, #522 and #563.
g) One manager confirmed there are 4 upright dry storage carts with rusted wheels in use in the dietary department. [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 kept clean and sanitary and are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the Resident exhibiting a wound has been reassessed at least weekly by a member of the Registered Nursing staff, if clinically indicated as evidenced by:
a) Chart review for a Resident revealed that the Resident had a wound.
b) Staff interview with a Registered staff member revealed that wound assessment and documentation should be completed in the Wound Assessment tool in Point Click Care upon admission and at least weekly.
c) Staff interview with a Registered staff member confirmed that the weekly wound assessment was missed for this Resident. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that Residents exhibiting a wound are reassessed at least weekly by a member of the Registered Nursing staff if clinically indicated, to be implemented voluntarily.

WN #8: 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. (5) The licensee shall ensure,
(a) that the drug destruction and disposal system is audited at least annually to verify that the licensee's procedures are being followed and are effective; O. Reg. 79/10, s. 136 (5).
(b) that any changes identified in the audit are implemented; and O. Reg. 79/10, s. 136 (5).
(c) that a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 136 (5).

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee failed to ensure that when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable as evidenced by:
a) Interview by Inspector #213 with a Registered staff member and Director of Resident Care confirmed that they were unaware of the process for drug destruction.
b) Interview with an identified staff member confirmed that they are responsible for the drugs for destruction. This staff member reported that when the red bio-hazardous waste bag of drugs for destruction is full, they seal the box with the bag in it, mark it "RX" and the pharmacy comes to pick up the box for destruction.
c) The identified staff member confirmed that the drugs are not altered or denatured prior to leaving the home.
d) The Director of Resident Care along with Inspectors #213 and #522 opened a sealed box marked "RX" and found a red bio-hazardous waste bag containing plastic bags of medications in their original form in labeled strip packages. The Director of Resident Care confirmed that this box was ready for pick up by the pharmacy and that the drugs were not altered or denatured. [s. 136. (6)]

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 when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable, to be implemented voluntarily.

WN #9: 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:
a) Inspector #522 observed a Registered staff member administer medications to Residents. The Inspector observed the Registered staff member administer medications to 6 Residents without hand washing.
b) When administering medication to a Resident the Inspector observed the Registered staff pour the Resident's pills into the nurse's hand and then into the medication cup.
c) When administering medication to another Resident, the Inspector observed the Registered staff pick up a pill that had fallen onto the top of the medication cart put it in a medication cup and administer it to the Resident.
d) When administering medication to another Resident the Inspector observed the Registered staff punch a pill from a bubble pack out into the nurse's hand and then put the pill into a medication cup.
e) During the medication pass the Registered staff member left to answer the phone at the nurse's station and then proceeded to administer medications without hand washing. [s. 229. (4)]

2. The licensee failed to ensure staff participate in the implementation of the infection prevention and control program as evidenced by:
a) On March 25, 2014, the following observations were made:
i) An unlabeled wash basin was found on the counter of a shared washroom, a four bed Resident room.
ii) An unlabeled bottle of Equate mouthwash was found on the counter of a shared washroom, a semi private Resident room.
iii) An unlabeled urine collection jar and container were observed on the counter of a shared washroom, a four bed Resident room.
iv) Two soiled wash cloths were found in the washroom sink in a resident washroom.
v) Inspector #213 observed an unlabeled used electric toothbrush in washroom shared by four Residents.
b) The Infection Control Coordinator confirmed non-registered staff are responsible for labeling all Resident personal hygiene items on admission and as required thereafter, despite the type of accommodation the Resident resides in.
c) The infection prevention and control policy related to Cleaning Resident Care Equipment provides directives for non-registered staff to label single resident-use equipment with the residents name and to use the equipment only for the resident for which it is labeled. [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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Licensee failed to ensure that every Resident was afforded privacy in treatment and in caring for his or her personal needs as evidenced by:
a) Inspector #522 observed a Registered staff member administer medication by injection to a Resident. This occurred in the common area outside a dining room. (522)
b) Inspector #144 observed a Registered Staff member initiating a treatment for a Resident in a television lounge area. On inquiry, the staff member stated there were too many Residents in wheelchairs in front of the Resident's room and that normally treatments are provided in the Resident's rooms. On observation, a music activity was starting in the television area and two resident wheelchairs were in front of this Resident's room. A second registered staff confirmed that Resident treatments are expected to be completed in the privacy of their room. (144)
c) Medication administration observation on 2 occasions by Inspector #563 revealed the Registered Practical Nurse left the medication cart unattended with personal health information displayed on the electronic tablet secured to medication cart. [s. 3. (1) 8.]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2007, c. 8, s. 31 (2).
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure the restraining of a Resident by a physical device is included in a resident's plan of care only if all of the following are satisfied: a physician has ordered or approved the restraining, the restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent and the plan of care provides for everything required under this subsection as evidenced by:
a) Staff interview with a Registered staff member revealed there was no order or consent obtained for the use of the seat belt and tilt recline on manual wheelchair for a Resident.
b) The Registered staff confirmed there should be an order and consent completed as this Resident would not likely be able to undo the seat belt independently and could not incline the wheelchair or get out of the wheelchair when reclined without assistance.
c) Chart review of this Resident's care plan revealed there are no goals or interventions to address restraints and devices used. Tilt recline on manual wheelchair and seat belt are absent from care plan. [s. 31. (2)]

WN #12: 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 drugs are stored in an area or a medication cart that is secure and locked as evidenced by:
a) A zip lock plastic bag with six bottles of prescription medications inside belonging to a Resident was observed by Inspector #144 on the nursing station desk.
b) It was further observed by Inspector #144 that there were no registered staff in the vicinity of the nurses desk.
c) Two Registered staff acknowledged to Inspector #144 that medication should not be left in the open unattended and that the medication bag should have been locked in the medication room. [s. 129. (1) (a)]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 29th day of April, 2014

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

Rhonda Kukoly

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RHONDA KUKOLY (213), CAROLEE MILLINER (144), JULIE LAMPMAN (522), MELANIE NORTHEY (563)
Inspection No. / No de l'inspection :	2014_229213_0021
Log No. / Registre no:	L-000271-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 11, 2014
Licensee / Titulaire de permis :	c/o Southbridge Management Services LP ~~DIVERSICARE VI LIMITED PARTNERSHIP~~ ~~458 Glencairn Avenue, TORONTO, ON, M5N-1V7~~ 150 Water St. S. suite 201. Cambridge, Ont. N1R 3E2
LTC Home / Foyer de SLD :	CHELSEY PARK (OXFORD) NURSING HOME 310 OXFORD STREET WEST, LONDON, ON, N6H-4N6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SUZI HOLSTER

To DIVERSICARE VI LIMITED PARTNERSHIP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

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.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee must prepare, submit and implement a plan to ensure that all doors leading to the outside of the home, including balconies and terraces, are kept closed and locked, equipped with a door access control system that is kept on at all times, and is equipped with an audible door alarm that allows calls to be canceled only at the point of activation. The plan must include what immediate and long-term actions will be undertaken to correct the identified deficiencies, as well as identify who will be responsible to correct the deficiencies and the dates for completion.

Please submit the plan, in writing, to Rhonda Kukoly, Long-Term Care Homes Nursing Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, Ontario, N6A 5R2, by email, at Rhonda.kukoly@ontario.ca by May 9, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that all doors leading to the outside of the home, including balconies and terraces, are kept closed and locked, equipped with a door access control system that is kept on at all times, and is equipped with an audible door alarm that allows calls to be canceled only at the point of activation as evidenced by:
a) On March 25 and 28, 2014, on 2nd floor, the sliding door leading to an outside balcony was observed open approximately 10cm with a chain locked with a key on the top of the door preventing it from opening further. The Registered Nurse confirmed that the key controlled door alarm system had been placed on bypass.
b) On March 25 and 28, 2014, on 4th floor, the sliding door leading to an outside balcony was observed locked with a chain locked with a key on the top of the door, however, when opened by the nurse, there was no audible alarm heard that indicated the door had been opened. The Registered Nurse confirmed that the key controlled door alarm system was not functioning properly.
c) The Director of Resident Care confirmed that it is an expectation that all doors to balconies are kept closed and locked at all times and the audible door alarm is on and functioning properly at all times.
(213)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 01, 2014

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, 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;

(b) is on at all times;

(c) allows calls to be cancelled only at the point of activation;

(d) is available at each bed, toilet, bath and shower location used by residents;

(e) is available in every area accessible by residents;

(f) clearly indicates when activated where the signal is coming from; and

(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).

Order / Ordre :

The licensee must prepare, submit and implement a plan to ensure that the resident-staff communication and response system is available in every area accessible by residents. The plan must include what immediate and long-term actions will be undertaken to correct the identified deficiencies, as well as identify who will be responsible to correct the deficiencies and the dates for completion.

Please submit the plan, in writing, to Rhonda Kukoly, Long-Term Care Homes Nursing Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, Ontario, N6A 5R2, by email, at Rhonda.kukoly@ontario.ca by May 9, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that the resident-staff communication and response system is available in every area accessible by residents as evidenced by:
a) There were no call bell pull stations observed in the dining rooms or the resident lounges on 2nd, 3rd, 4th or 5th floors. There were whistles tacked to the wall in every dining room with signs indicating "in case of emergency - use whistle"
b) The Administrator and the Director of Resident Care confirmed that there is no resident-staff communication and response system in the dining rooms or the resident lounges on all 4 resident care floors.
(213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 01, 2014