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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 7, 2015	2015_205129_0005	H-002121-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD THOROLD ON L2V 4T7

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

DEER PARK VILLA
150 CENTRAL AVENUE GRIMSBY ON L3M 4Z3

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

PHYLLIS HILTZ-BONTJE (129), CATHY FEDIASH (214), KELLY HAYES (583), ROSEANNE WESTERN (508)

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 9, 10, 11, 12, 16. 17, 18 and 19, 2015

Additional inspections completed at the time of this RQI included a Critical Incident Inspection (#H-001433-14) and two Complaint inspections (#H-001534-14 and #H-001923-15)

During the course of the inspection, the inspector(s) spoke with residents and resident's family members, registered and unregulated nursing staff, Registered Dietitian, Food Services Manager, Recreationist,President of the Residents Council,Interim Director of Resident Care and the Acting Administrator.
During the inspection inspectors also observed residents, reviewed clinical record information, reviewed trust account information, reviewed home policies and procedures, reviewed annual program evaluation information and completed a tour of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing
Trust Accounts

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

11 WN(s)
5 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (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).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for each resident set out clear directions to staff and others who provided direct care to the resident.

a) The plan of care was reviewed for resident #006 and identified the resident was at high nutrition risk. The nutrition Resident Assessment Protocol (RAP) dated January 25, 2015 stated "no supplements are provided at this time" and an intervention to start supplements was not identified. The nutrition progress note dated January 28, 2015 explained resident #006 was on 60 milliliters of Ensure Plus for afternoon and evening snack. The nutrition care plan interventions identified resident #006 was to be provided

235 milliliters of Ensure Plus at breakfast and supper and 125ml at morning, afternoon and evening snack. The medication administration recorded dated March 1 to 17, 2015 directed registered nursing staff to provide resident #006 with 60ml of Ensure Plus in a clear medicine cup three times per day and to offer additional Ensure Plus if resident #006 refused their meal. In an interview with the RD on March 18, 2015 it was confirmed that the plan of care for resident #006 did not set out clear direction to staff for the method, amount and times of ensure plus to be provided.

b) The plan of care was reviewed for resident #003 and identified the resident was at high nutrition risk.

i) A review of the nutrition care plan interventions dated March 17, 2015 directed staff to weigh resident #003 monthly. The physician's orders dated March 17, 2015 directed staff to weigh resident #003 every 15 days. In an interview with the RD on March 18, 2015 it was confirmed clear direction was not provided as to how often to weigh resident #003.

ii) A review of the nutrition care plan interventions dated March 17, 2015 directed staff to provide Nutren 1.5 at 70 milliliters over an identified time period. The physician orders dated March 17, 2015 (initial created on February 25, 2015) directed staff to provide Nutren 1.5 at 75 milliliters over an identified time period. The RAP assessment completed on February 8, 2015 identified resident #003 was receiving Nutren 1.5 at 70 milliliters over an identified time period and the nutrition progress note completed on February 12, 2015 identified resident #003 was receiving Nutren 1.5 at 75 milliliters over an identified time period. In an interview with the RD on March 18, 2015 it was confirmed clear direction was not provided for the administration of Nutren 1.5.

iii) The nutrition progress note completed on February 12, 2015 identified resident #003's hydration status did not appear adequate and that there had been a miscommunication of water required for a nutritional treatment. The nutrition care plan interventions directed staff to use 30 milliliters of water before and after medications and when starting and stopping the treatment. In addition 100 milliliters of water was to be added to the treatment at 1000, 1400, 1800 and 2100 hours. In an interview with the RD on March 18, 2015 it was confirmed that these were the current water orders for resident #003 and they were based on the nutrition assessment completed February 12, 2015.

The medication administration record was reviewed from March 1 to March 17, 2015 and included the following water orders for the treatment. 1) Provide 30 millilitres of water at

0600 and 2200 hours when starting and stopping the treatment. 2) Provide 30 milliliters of water at 0800, 1200, 1600, 2000 hours. 3) Provide 15 milliliters of water before and after medications. 4) Provide 30 milliliters of water before and after medications. 5) Provide 100 milliliters of water at 0800, 1200, 1600, 2000 hours. 6) Provide 100 milliliters of water at 0600, 1000, 1230, 1630, 2030 hours.

In an interview with the RD on March 18, 2015 it was identified that there were multiple conflicting orders for water in the mediation administration record and each had been documented as being used by the registered nursing staff during the time period of March 1 to 17, 2015. It was confirmed clear direction was not provided to staff related to the amount of water and scheduled times water was to be used for resident #003's treatment. [s. 6. (1) (c)]

2. The licensee failed to ensure that resident #10 was reassessed and the plan of care reviewed and revised when the care set out in the plan had not been effective, in relation to the following: [6(10)(c)]
Resident #10 was not reassessed and the plan of care was not reviewed or revised when care set out in the plan of care was not effective in reaching the identified care goals related to reducing three identified responsive behaviours. The Interim Director of Resident Care (I-DRC) confirmed the following information:
-A Minimum Data Set Review (MDS) completed on June 15, 2014 indicated the resident's mood and behaviour symptoms had not changed over the previous 90 day period of time. Despite staff identifying care goals that indicated there was to be an improvement in both the resident's mood and behavioural status no changes to the goals of care or the care interventions were made following confirmation that the care provided to the resident over the preceding 90 days had not been effective in moving towards the care goals established for this resident.
-A (MDS) review completed on September 7, 2014 indicated the resident's mood and behaviour symptoms had not changed over the previous 85 day period of time. Despite staff identifying care goals that indicated there was to be an improvement in both the resident's mood and behavioural status, no changes to the goals of care or the care interventions were made following confirmation that the care provided to the resident had not be effective in moving towards the care goals established for this resident.
-A (MDS) review completed on November 9, 2014 indicated the resident's mood and behaviour symptoms had not changed over the previous 63 day period of time. Despite staff identifying care goals that indicated there was to be an improvement in both the resident's mood and behavioural status no changes to the goals of care or the care interventions were made following confirmation that the care provided to the resident had

not be effective in moving towards the care goals established for this resident.
-A (MDS) review completed on January 25, 2015 indicated the resident's mood and behaviour symptoms had not changed over the previous 79 day period of time. Despite staff identifying care goals that indicated there was to be an improvement in both the resident's mood and behavioural status no changes to the goals of care or the care interventions were made following confirmation that the care provided to the resident had not be effective in moving towards the care goals established for this resident. [s. 6. (10) (c)]

3. The licensee has failed to ensure that the plan of care was revised when care set out in the plan had not been effective and different approaches considered in the revision of the plan of care.

Resident #200 demonstrated four identified responsive behaviours. In September, 2014, the Resident Assessment Protocol (RAP) had indicated that the resident had deteriorated and their behaviours had worsened. Later in that month, it had been identified that the resident had developed a wound. A review of the resident's clinical record also indicated that the resident was monitored regularly for dehydration due to a low intake of fluids.

A review of the resident's plan of care for September, 2014, and January, 2015, indicated that there had been no changes in the interventions developed to manage the identified behaviours. The resident continued to demonstrate these responsive behaviours.

It had been identified in September, 2014, that the resident had worsened responsive behaviours, however; the plan of care was not revised or different approaches had not been considered when the care set out in the plan was not effective.

During an interview with registered staff on March 19, 2015, it was confirmed that the plan of care was not revised when the care set out in the plan was not effective. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring compliance with 6(1)(c) and 6(11)(b) of the Act, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #006, resident #010 and resident #011's plans of care were based on an interdisciplinary assessment of a recurring health condition, in relation to the following: [26(3) 10]
a) Resident #006's plan of care was not based on an interdisciplinary assessment of an identified recurring condition. The clinical record and information provided by the I-DRC confirmed that this resident received treatment for this recurring condition five times in 2014 and twice in 2015. The clinical record indicated that when the recurring condition was presenting there was also an increase in the responsive behaviours being demonstrated by the resident. Staff and the clinical record confirmed that short term care plans were developed each time the recurring condition was confirmed and these plans were not based on an interdisciplinary assessment of the recurring health issue either from an infection control perspective or as strategy for the management of responsive behaviours.

b) Resident #010's plan of care was not based on an interdisciplinary assessment of a recurring condition. The clinical record and information provided by the I-DRC confirmed that this resident received treatment for this recurring condition three times in 2014 and once in 2015 The clinical record indicated that when the identified condition was recurring the resident also demonstrated an increase in responsive behaviours. Staff and the clinical record confirmed that short term care plans were developed each time the recurring condition was confirmed and these plans were not based on an interdisciplinary assessment of the recurring health issue either from an infection control perspective or as strategy for the management of responsive behaviours.

c) Resident #011's plan of care was not based on an interdisciplinary assessment of a recurring condition. The clinical record and information provided by the I-DRC confirmed that this resident received treatment for this condition three times in 2014. Staff and the clinical record confirmed that short term care plans were developed each time this condition was confirmed and these plans were not based on an interdisciplinary assessment of the recurring health issue either from an infection control perspective or as strategy for the management of responsive behaviours. [s. 26. (3) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring plans of care are based on an interdisciplinary assessment of recurring health conditions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that an assessment was completed to determine possible behavioural triggers for the behaviours being demonstrated by resident #10. [53(4)(a)]
Clinical documentation indicated that resident #10 demonstrated five responsive behaviours over a seven month period of time between June 2014 and January 2015. Clinical documentation confirmed that an attempt to identify possible behavioural triggers for the behaviours being demonstrated by resident #10 had not been made. The I-DRC confirmed that possible triggers for these behaviours were not included in the resident's plan of care and that there was not a mechanism/protocol in place in the home for staff to use to guide them in identifying possible behavioural triggers. [s. 53. (4) (a)]

2. The licensee has failed to ensure that behavioural triggers were identified for the resident demonstrating responsive behaviours.

Resident #200 had been identified as demonstrated three responsive behaviours. A review of the resident's clinical record indicated that the resident's responsive behaviours had worsened in September, 2014. The resident's plan of care had identified the resident's responsive behaviours and interventions had been developed and implemented, however; triggers for the resident's responsive behaviours had not been identified.

It was confirmed by registered staff that behavioural triggers had not been identified for resident #200. [s. 53. (4) (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 and ensuring that when a resident demonstrates responsive behaviours the behavioural triggers are identified, where possible, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with a weight change of 10 per cent of body weight, or more, over 6 months were assessed using an interdisciplinary approach and that actions were taken and outcomes were evaluated.

A review of the plan of care for resident #006 identified they were at moderate nutrition risk and had a 15 per cent weight loss over 6 months with a weight decrease between September 2014 and March 2015. The "Weight Monitoring" policy (RS00-015), revised May 16, 2013 directs nursing and dietary staff to follow a collaborative procedure to respond to resident's unplanned significant weight changes. The clinical records from March 1 to March 18, 2015 identified that resident #006's significant weight change had not been assessed. In an interview with the Registered Dietitian on March 18, 2015 it was confirmed they were unaware of resident #006's weight change of 10 per cent of body weight or more of 6 months and that the resident's weight change had not been assessed using an interdisciplinary approach. [s. 69. 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring residents with a weight change of 10 per cent of body weight, or more, over 6 months were assessed using an interdisciplinary approach and that actions were taken and outcomes were evaluated., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining service included proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

During meal service on March 9, 2015, it was observed that resident #201 required total assistance with eating and drinking their lunch. Resident #201 was seated in a large wheelchair and was being assisted by a staff member.
During the meal service the staff member was observed to be standing up while assisting resident #201.

It was confirmed by registered staff on March 9, 2015, that the staff member was standing while assisting resident #201 and the proper technique required the staff member to be seated while assisting the resident. [s. 73. (1) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring,dining service includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments and interventions were documented.

a) A review of the plan of care for resident #010 identified the resident was at moderate nutrition risk, developed a wound in January 2015 and were referred to the Registered Dietitian (RD) for assessment. In an interview with the RD on March 18, 2015 they shared resident #010's altered skin integrity was assessed and no nutrition interventions were required at the time of assessment. The RD confirmed that documentation of resident #010's skin assessment had not been included in the Nutrition Resident Assessment Protocol (RAP) completed on January 25, 2015 or the nutrition progress note completed on January 28, 2015.

b) A review of the plan of care for resident #011 identified the resident was at moderate nutrition risk, developed a wound in November 2014 and were referred to the RD for assessment. In an interview with the RD on March 18, 2015 they shared resident #011's altered skin integrity was assessed and no nutrition interventions were required at the time of assessment. The RD confirmed that documentation of resident #011's skin assessment had not been included in the Nutrition RAP completed on November 30, 2014 or the nutrition progress note completed on December 4, 2014.

c) A review of the plan of care for resident #003 identified the resident was at high nutrition risk, developed a wound in February 2015 and were referred to the RD for assessment. It was documented in the physician orders that resident #003 was ordered four scoops of Beneprotein instant protein powder in February 2014. A review of the plan care from February 2014 to January 2015 identified there was no documented skin assessment completed by the RD and protein powder was not identified as an intervention in resident #003's nutrition care plan interventions. In an interview with the RD on March 18, 2015 it was confirmed that the actions taken with respect to resident #003's nutrition assessment and intervention related to altered skin were not documented. [s. 30. (2)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration was in place.

A review of the plan of care for resident #003 identified they were at high nutrition risk, had a period of significant weight loss over the past six months and required a individual dietary intervention. In an interview with two registered nursing staff on February 17, 2015 they shared that they were not aware of a process for documenting resident #003's intake. A review of the nutritional order in the medication administration record identified that a daily intake number ranging from 0 to 750 was recorded from March 1 to March 14, 2015. In an interview with the Registered Dietitian on March 18, 2015 it was shared that resident #003 received a total of 1200ml of food and fluids and the information required to accurately monitor and evaluate resident #003's intake was not available. In an interview with the Director of Care on March 19, 2015 it was confirmed that a system to monitor and evaluate resident !003's intake related to this individualized dietary intervention was not in place. [s. 68. (2) (d)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's menu cycle was reviewed by the Resident's Council. [71(1) (f)]
The Resident's Council President and minutes of the council meetings from February 2014 to February 2015 confirmed that although the Resident's Council were asked for input into the development of the menu cycle, the Resident's Council were not given the opportunity to review the completed menu cycle. [s. 71. (1) (f)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the results of the satisfaction survey were made available to the Resident's Council. [85(4)(a)]
The Resident's Council President and minutes of the council meetings from February 2014 to February 2015 confirmed that the results of the annual satisfaction survey were not provided to the Resident's Council. [s. 85. (4) (a)]

WN #10: 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 steps were taken to ensure the security of the drug supply, including the following: A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies and that immediate action is taken if any discrepancies are discovered.

An interview with the I-DRC on March 12, 2015, confirmed that the home does not complete monthly audits of the daily count sheets of controlled substances to determine discrepancies. [s. 130. 3.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The license failed to ensure the improvements made to the quality of the accommodation, care, services, programs and goods were communicated to the resident were communicated to the Resident's Council. [228(3)]
The Resident's Council President and minutes of the council meetings from February 2014 to February 2015 confirmed that improvements made to the accommodation, care, services, programs and goods provided to the residents were not provided to the Resident's Council. [s. 228. 3.]

Issued on this 7th day of May, 2015

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

Original report signed by the inspector.