Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 25, 2014	2014_211106_0007	S-000089-14	Resident Quality Inspection

Licensee/Titulaire de permis

RIVERSIDE HEALTH CARE FACILITIES, INC.
110 VICTORIA AVENUE, FORT FRANCES, ON, P9A-2B7

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

EMO HEALTH CENTRE
170 FRONT STREET, P. O. BOX 390, EMO, ON, P0W-1E0

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

MARGOT BURNS-PROUTY (106), KARI WEAVER (534)

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 17, 18, 19, 20, 24, 25, 26, 27, 2014

The following log was completed as part of the RQI inspection: Log# S-000089-14

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Secretary, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides (DA), Activity Staff, Housekeeping Staff, Maintenance Staff, Family Members and Residents.

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home, reviewed resident health care records and reviewed home policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Quality Improvement
Recreation and Social Activities
Residents' Council
Skin and Wound Care
Trust Accounts

Findings of Non-Compliance were found during this inspection.

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. A Resident Assessment Protocol (RAP) note for resident #527 was reviewed, which

indicated, the resident's toileting abilities have declined. The care plan document was also reviewed and it did not indicate the way in which the resident is toileted. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. Resident # 537 was observed by inspector #534 on March 17 and 18, 2014, to have 2 side rails in use. Staff #S-100 stated in an interview on March 25, 2014, that resident # 537 uses 2 or 3 side rails. Review of the resident's RAI-MDS indicated the use of 2 side rails used daily. Review of the resident's flow sheet for March 2014 identifies, documentation for 3 side rails. On the contrary, review of resident #537 care plan did not outline the use of any side rails for the resident. The licensee failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. Resident # 535 was observed by inspector #534 on March 17 and 18, 2014, to have 3 side rails in use. Staff #S-100 stated in an interview on March 25, 2014, that resident # 535 uses 3 side rails and a bed alert alarm. Review of the resident's RAI-MDS from February 6, 2014, indicated the use of 2 full side rails daily. Review of the resident's flow sheet has documentation for 3 side rails for January 2014, February 2014, and March 2014. Review of resident #535's care plan regarding the use of side rails states "transferring: bed rails used for bed mobility or transfer". The care plan does not specify how many side rails to use or indicate the use of the bed alert alarm. The licensee failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

4. Resident # 532 was observed by inspector #534 on March 17 and 18, 2014, to have 3 side rails in use. Staff #S-100 stated in an interview on March 25, 2014, that resident # 532 uses 3 side rails. Review of the resident's RAI-MDS indicated the use of "other type side rails" used daily. Review of the resident's flow sheet has documentation for 3 side rails for January 2014, February 2014, and March 2014. Review of resident #537's care plan did not outline the use of any side rails for the resident. The licensee failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

5. Inspector noted from review of resident #532's health care record that they had been experiencing pain. The care plan document for resident #532 was reviewed and

it did not contain a section related to pain, nor did it have any interventions for staff to follow when the resident is experiencing pain. During the review of resident #532's progress notes, inspector #106 noted that the staff implement various interventions to relieve the resident's pain.

On March 24, 2014, inspector #534 conducted an interview with a RPN and the RPN reported to inspector #534, that staff are currently trialling various interventions to address the resident's pain, none of these interventions are indicated in resident #532's care plan document. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident, specifically regarding the side rails that are used for residents # 534, 535, 532, as well as pain interventions used for resident #532, to be implemented voluntarily.

WN #2: 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. On March 24, 2014, the DOC told inspector #106 that although the home has created a Continence Care and Bowel Management program, including policies, procedures and assessment tools and provided training to the majority of staff, the program is not currently implemented in the home. The DOC also reported that the home does not plan to implement the Continence Care and Bowel Management program until sometime after April 1, 2014. The licensee failed to ensure that 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, is in compliance with and is implemented in accordance with applicable requirements under the Act. [s. 8. (1) (a),s. 8. (1) (b)]

2. On March 24, 2014, the DOC told inspector #106 that although the home has created a Pain Management Program, including policies, procedures and assessment tools and provided training to the majority of staff, the program is not currently implemented in the home. The DOC also reported that the home does not plan to implement the Pain Management Program until sometime after April 1, 2014. The licensee failed to ensure that 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, is in compliance with and is implemented in accordance with applicable requirements under the Act. [s. 8. (1) (a),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 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, is in compliance with and is implemented in accordance with applicable requirements under the Act, specifically in regards to the home's Continence Care and Bowel Management Program and the Pain Management Program, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. On March 17 - 20, 2014 and March 24 -27, 2014, during the hours of 0800hrs to 1600hrs, the main door to the home was found to be unlocked and inspector could enter and exit the home by simply opening the main door. The main door opens onto the home's parking lot. The DOC stated that the door is locked after 2000hrs and if a resident with a wander guard device gets too close to the door (at any time of day), an alarm will sound and the door will automatically lock. The licensee failed to ensure that 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, kept closed and locked. [s. 9. (1) 1. i.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to 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, kept closed and locked, specifically in regards to the main entrance to the home, to be implemented voluntarily.

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

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

Findings/Faits saillants :

1. Health Care Record for various residents (resident #524, 528, 529, 530, 531, 532, 534, 535, 536, 537) were reviewed and no completed bed rail assessments were found. On March 25, 2014, during an interview the DOC told inspector #106 that the home does not currently complete bed rail assessments for any residents.

Inspector #534 found that the beds that the residents use in the home are hospital beds by "Stryker" according to the home's DOC. The beds have an upper and lower side rails that can be raised or lowered on each side of the bed.

Staff #S-100 was asked by inspector #534, if any assessment tool for side rail use and resident entrapment zones were used to minimize risk to residents in the home. Staff #S-100 stated that no assessment tool was being used in the home to assess for bed

rail safety and entrapment and that staff determine how many rails should be used without using a tool.

Staff #S-101 confirmed in an interview with inspector #534 that no tools for bed safety and entrapment are currently used in the home. Furthermore, staff determine how many rails to use with each resident without using an assessment tool. [s. 15. (1) (a)]

2. On March 25, 2014, during an interview a RPN confirmed that 4 bed rails are used for resident #536. [s. 15. (1) (a)]

3. Resident #524 was observed by inspector #534 on March 17 and 18, 2014, to have 3 side rails in use. The use of the 3 side rails for resident #524 was confirmed in an interview with staff #S-100 on March 25, 2014 at 1400hrs. Review of the resident's care plan and RAI-MDS indicated the use of the side rails for resident positioning. [s. 15. (1) (a)]

4. Resident #529 was observed by inspector #534 on March 17 and 18, 2014, to have 3 side rails in use. The use of the 3 side rails and bed alarm for resident #529 was confirmed in an interview with staff #S-100 on March 25, 2014. Review of the resident's care plan and RAI-MDS indicated the use of the side rails for patient support. [s. 15. (1) (a)]

5. On March 26, 2014, during an interview a RPN confirmed that 2 bed rails are used for resident #534. [s. 15. (1) (a)]

6. On March 26, 2014, during an interview a RPN confirmed that 4 bed rails are used for resident #531. [s. 15. (1) (a)]

7. On March 26, 2014, during an interview a RPN confirmed that 1 bed rails are used for resident #530. [s. 15. (1) (a)]

8. On March 26, 2014, during an interview a RPN confirmed that 2 top bed rails are used for resident #528. [s. 15. (1) (a)]

9. Resident # 537 was observed by inspector #534 on March 17 and 18, 2014, to have 2 side rails in use. Staff #S-100 stated in an interview on March 25, 2014 that resident # 537 uses 2 or 3 side rails. Review of the resident's RAI-MDS indicated the use of the side rails for resident positioning. [s. 15. (1) (a)]

10. Resident # 535 was observed by inspector #534 on March 17 and 18, 2014, to have 3 side rails in use. Staff #S-100 stated in an interview on March 25, 2014, that resident # 535 uses 3 side rails and a bed alert alarm. Review of the resident's RAI-MDS indicated the use of the 2 full side rails. Flow sheet documentation reviewed for resident #535 indicated the use of 3 side rails with the bed alert alarm for January 2014, February 2014, and March 2014. [s. 15. (1) (a)]

11. Resident # 532 was observed by inspector #534 on March 17 and 18, 2014, to have 3 side rails in use. Staff #S-100 stated in an interview on March 25, 2014, that resident # 532 uses 3 side rails.

The licensee failed to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. On March 20, 2014, inspector #106 interviewed registered staff members # S-103,

S-104 and S-105 and they reported that the home does not use a pain assessment instrument that is specifically designed for pain assessment. They stated that residents are assessed for pain when the RAPs are done.

The registered staff members reported to inspector 106, that the home does not have a specific pain assessment tool and that pain is assessed by monitoring the MARs to determine if prn analgesics are administered more regularly for specific residents and pain is also assessed on the "Seven Day Observation and Monitoring Form". On March 24, 2014, the DOC also verified that there is no specific pain assessment instrument currently being used in the home.

On March 20, 2014, staff member # S-105 provided the inspector copies of "Long Term Care Pain Assessment Tool" and "Long Term Care Pain Monitoring Flow Sheet" and stated that these tools are not currently implemented in the home. The health care records of various residents (resident #521, 527, 532, 536) who had experienced pain, were reviewed and no pain assessments using a clinically appropriate assessment instrument specifically designed for assessing pain were found.

Progress notes for resident #527 were reviewed from February 1 to July 1, 2013, which indicated that the resident experienced pain on ten different days in March 2013. The care plan document for resident #527 was also reviewed, which indicated to give the resident time to adjust to pain in joints when transferring. [s. 52. (2)]

2. During a March 24, 2014, interview the DOC told inspector #106, staff had noted that resident #521 had been exhibiting facial expressions, such as wincing and were unsure if the resident was experiencing pain or some other type of discomfort. On Feb 24, 2014, the resident was ordered and received an analgesic. [s. 52. (2)]

3. Progress notes for resident #536, from December 2013 to March 2014, were reviewed by inspector #106, on 6 different days the resident voiced complaints of pain to staff. During stage one of this inspection, inspector #106 asked resident #536 if they were experiencing pain, they indicated they were.

The "Seven Day Observation and Monitoring Form" dated from February 2014 was reviewed, which indicated the resident complained of moderate pain on 5 of the 7 days. A RAI MDS assessment was also reviewed, which indicated the resident had moderate pain, less than daily and received analgesics on 7 out of 7 days. [s. 52. (2)]

4. Progress notes for resident #532, from November 2013 to March 2014, were reviewed by inspector #106, on 21 different days the resident voiced complaints of pain to staff. A RAI MDS assessment was also reviewed, which indicated the resident had moderate pain, daily. On March 24, 2014, inspector #534, interviewed a RPN and the RPN told inspector #534 that the resident has daily pain.

The licensee failed to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident's pain is not relieved by initial intervention, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, specifically in regards to resident #536 and #532, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. On March 26, 2014, during the observation of the 1600-1700 medication pass, staff #S-102 was noted to have administered 3 pills in a clear medication cup to resident # 528 while the resident was sitting at their chair in the dining room. The medication cup was placed on the resident's place mat and left for the resident to take. Staff #S-102 signed in the medication book that the medications were taken by the resident. Inspector observed, the resident did not take the pills given to her. The staff member continued to proceed out of the dining room and did not witness the resident taking the medications.

The licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. [s. 131. (5)]

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 no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #7: 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. On March 26, 2014, during an interview, the DOC told that inspector that although the home does conduct Quality Improvement monitoring, analyzing and evaluation, there are no written descriptions of the home's Quality Improvement program. The licensee failed to ensure that the home's quality improvement and utilization review system provides a written description of its goals, objectives, policies, procedures and protocols, and a process to identify initiatives for review. [s. 228. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's quality improvement and utilization review system provides a written description of its goals, objectives, policies, procedures and protocols, and a process to identify initiatives for review, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The health care record for resident # 525 was reviewed by inspector #106. The resident's continence care needs were assessed in November 2009, using a "Continence Assessment Form", which indicated, the resident was continent and independent for use of the toilet.

"Care Flow Sheets" for resident #525, from Oct 2013 to Feb 2014 were reviewed, which indicated the resident was incontinent multiple times. A "Seven Day Observation and Monitoring Form", for Jan 2014, was also reviewed, which indicated the the resident required total assistance with toilet use multiple times and was incontinent multiple times.

On March 20, 2014, the inspector interviewed a RN and 2 RPNs regarding continence assessments, they reported to the inspector that a continence assessment is completed on admission for residents using a specific continence assessment tool but, the form is not utilized after admission. The 3 registered staff members indicated that if a resident has a change in continence that it would be assessed in the RAPs, but a specific tool designed for continence is not used.

The licensee failed to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [s. 51. (2) (a)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. On March 17, 2014, during the entrance interview the DOC reported that the home does not have a Family Council and that family members are informed of their right to establish a Family Council annually, but not semi-annually. The licensee failed to ensure that if there is no Family Council established in the home to convene semi-annual meeting to advise such persons of the right to establish a Family Council. [s. 59. (7) (b)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)

(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. On March 18, 2014, the DOC indicated on the "LTCH Licensee Confirmation Checklist - Admission Process" that the home's admission package does not include information about the home's policy to promote zero tolerance of abuse and neglect. On March 26, 2014, the DOC gave the inspector a copy of the home's admission package to review and the inspector found that there was no information regarding the home's policy to promote zero tolerance of abuse and neglect of residents. The licensee failed to ensure that the admission information package includes at a minimum, the long-term care home's policy to promote zero tolerance of abuse and neglect of residents. [s. 78. (2) (c)]

2. On March 18, 2014, the DOC completed the "LTCH Licensee Confirmation Checklist - Admission Process" and indicated that they only verbally provide information to residents regarding the Residents' Council. On March 26, 2014, the DOC provided the inspector with a copy of the home's Admission Package, the inspector reviewed the package and found that it did not contain any information regarding Residents' Council. The licensee failed to ensure that the home's admission package included, information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package. [s. 78. (2) (o)]

3. On March 18, 2014, the DOC completed the "LTCH Licensee Confirmation Checklist - Admission Process" and indicated that the home only verbally provide information to residents regarding the Family Council. On March 26, 2014, the DOC provided the inspector with a copy of the home's Admission Package, the inspector reviewed the package and found that it did not contain any information regarding Family Council. The licensee failed to ensure that the home's admission package included, information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations. [s. 78. (2) (p)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. During examination of the medication cart used in the home on March 26, 2014, inspector #534 found in the medication drawer for resident #534, a weekly home pill organizer for the resident. The container had one slot for each day of the week. In the tabs marked Sunday, Monday, Tuesday, Wednesday, and Thursday, there were multiple pills mixed together, unlabelled. The resident's name was hand written on a label on the underside of the container. Staff #S-101 confirmed the presence of the container in the medication cart drawer and stated they were most likely the resident's medications from home.

The licensee failed to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. [s. 126.]

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. During inspections of the medication cart on March 26, 2014, inspector # 534 found multiple expired medications in the medication room cupboard and in the medication cart. Specifically, for resident #531 expired Voltaren ointment tube with expiry date June 2013, bottle of Tylenol 325mg tablets with expiry date October 2013, and for resident #528- acetaminophen 500mg tablets with October 2013 expiry date. All expired medications were confirmed with staff #S-101.

The licensee failed to ensure that, (a) drugs are stored in an area or a medication cart, that complies with manufacturer's instructions for the storage of the drugs (e.g. expiration dates) within the locked medication cart. [s. 129. (1) (a)]

2. On March 27, 2014, during an interview regarding the storage location of the controlled substance lorazepam, staff member #S-101 and staff member #S-102 , confirmed to inspector #534, that the medication is located in the individual resident blister packs and not in a separate, double locked area within the medication cart.

The licensee failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. [s. 129. (1) (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
1. The resident's ability under subsection 82 (2) of this Regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1). O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. ON March 18, 2014, the DOC completed the "LTCH Licensee Confirmation Checklist - Admission Process" and indicated that it did not provide information on the ability to retain a physician or RN (EC) to perform the required services. On March 26, 2014, during an interview inspector #106 clarified with the DOC that the admission package did not provide information on the ability of residents to retain a physician or RN (EC) to perform the required services, and the DOC confirmed this. The inspector also reviewed a copy of the home's admission package and it did not contain any information regarding the residents' ability to retain a physician or RN (EC) to perform the required services. The licensee failed to ensure that the home's admission package included information on the the residents ability to retain a physician or registered nurse in the extended class to perform required services. [s. 224. (1) 1.]

WN #14: 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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. On March 24, 2014, during the dinner service a RPN was observed to clear dirty dishes and scrape left overs into the garbage then serve a residents their meals without practicing hand hygiene, this practice occurred multiple times while the inspector observed the dinner service. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

2. On March 26, 2014, during an interview the DOC reported to the inspector that residents have had or been offered pneumoccocus immunizations but have not been offered immunization against tetanus and diphtheria. The licensee failed to ensure that the following immunization and screening measures are in place: 3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. [s. 229. (10) 3.]

Issued on this 28th day of April, 2014

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