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
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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 6, 2015	2015_259520_0012	L-002166-15	Resident Quality Inspection

Licensee/Titulaire de permis

ATK CARE INC.
1386 INDIAN GROVE MISSISSAUGA ON L5H 2S6

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

EXETER VILLA
155 JOHN STREET EAST EXETER ON N0M 1S1

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

SALLY ASHBY (520), DONNA TIERNEY (569), RUTH HILDEBRAND (128)

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): April 14, 15, 16, 17, 21, 22, 23, 27, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Director of Support Services/Nutrition Manager, Director of Activities, Director of Restorative Care, RAI-Co-ordinator, Maintenance Manager, Administrative Assistant, four Registered Nurses, one Registered Practical Nurse, Registered Dietician, two Dietary Aides, Laundry Aide, 11 Personal Support Workers, three Families, 40plus Residents.

During the course of the inspection, the inspector(s) observed Residents and staff, toured Resident home areas, reviewed Resident's clinical records, dining observation, medication administration, review of Family and Resident Councils, internal investigative reports and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

13 WN(s)
12 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. 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. The licensee has failed to ensure that every resident was afforded the right to privacy.

A medication was observed being administered by a Registered Staff Member to an identified Resident in the dining room, during a meal service.

The Registered Staff Member confirmed that the medication was administered during the meal and acknowledged that Residents were not afforded privacy in treatment related to the administration of the medication as it was administered on a regular basis in the dining room. (128)

During observation of the medication pass three residents were observed receiving treatments that required privacy.

An interview with the Registered Staff Member confirmed it was not best practice to administer a treatment in the dining room but stated it was common practice at the home. The Registered Staff Member verified these treatments were given in the dining room in view of other Residents.

An interview with the Administrator and Director of Care verified it went against Residents' rights and dignity to administer treatments in the dining room. [s. 3. (1) 8.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

WN #2: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

A clinical record review for an identified Resident revealed that the Registered Dietitian had ordered a supplement on a specified date.

Further review of the Medication Administration Record revealed the order was not provided to the Resident until 38 days later.

The Resident had experienced ongoing weight loss since admission.

The Registered Dietitian confirmed that the order had not been implemented as prescribed.

The Administrator indicated that the order should have been implemented as ordered and that the expectation was that Residents were provided care as set out in their plan of care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system, was complied with.

A) Review of the Falls and Fall Prevention Policy revised January 6, 2014 revealed the following:
* A falls risk scale will be done in conjunction with all other RAI-MDS assessments on admission, quarterly, or after any hospital admission.

* The falls risk scale will indicate whether a resident is at low, medium or high risk for falls.

* Registered staff will announce a code pink after every Resident fall in the home. All staff from all departments will come together to discuss the fall and ways in which it may have been prevented. This discussion will be documented on the residents' chart under the Falls progress note. Information will be used from this discussion to prevent future

falls.

* Registered staff will refer the Resident to the Safe Client Handling Committee based on their level of risk and/or as deemed appropriate and initiate strategies/activities to reduce/minimize the risk of falls (eg. to Physiotherapy for assessment).

* Registered Staff will observe the Resident for pain or difficulty weight bearing if no injury is evident. Notify the attending physician and POA/SDM of the fall, interventions and status of the resident.

B) Review of Code Pink Policy revised December 5, 2014 revealed:
* The code pink will be held within two hours of the fall.

* The Registered staff will announce "code pink" alerting all staff to gather at the nurses station to discuss a Residents' recent fall.

* The Registered staff will document in the progress notes that a code pink was held and staff from any or all of the following departments who were in attendance: nursing, dietary, housekeeping, laundry, office and maintenance.

Record review revealed the following:
* An identified Resident had an unwitnessed fall.

* A Falls Risk Assessment was completed in 2011 for the Resident(no rating - low, moderate, high risk for falls).

* Review of Resident progress notes revealed no evidence of "code pink" notes for the Resident following the fall.

* There is no evidence that the Power of Attorney (POA) for the Resident was notified following the fall.

* The last Falls Risk Assessment for the Resident was completed in 2011 and there is no evidence of a fall assessment completed quarterly for the Resident.

* The Resident was not discussed on the Safe Client Handling Meeting Minutes following the Residents fall.

An interview with the Director of Care verified the missing information noted above and confirmed the home had not followed their own Falls & Fall Prevention Policy and Code Pink Policy.

C) Review of the Bed Entrapment Policy revised September 2014 revealed the following:
* A complete bed audit will be completed yearly in January including all beds, mattresses and bed rails. This audit will be documented on the "Safe Client Handling Audit".

* A monthly random audit will be completed throughout the year to ensure that all parts of the bed system are compatible.

An interview with the Director of Care (DOC) verified there had been no yearly bed audit completed. The DOC also confirmed there was no monthly audit of the beds and the parts of the bed to ensure compatibility. [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, is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On a date in April 2015 the bed for an identified Resident was observed with a full rail in the up position and the mattress was noted to slide easily off the bed.

The Administrator confirmed that the mattress was a potential entrapment risk and indicated that the home was looking at ways to remedy entrapment risk for all beds in the home. (128)

On a date in April 2015 four beds were identified with potential entrapment concerns. The following day three more beds were identified.

An interview with the Administrator confirmed the seven beds noted above as having potential entrapment concerns.

Review of the bed assessment done by the home demonstrated the following:
Joerns Assessment dated April 8, 2014, 32 of 47 (69%) beds failed in one or more zones. Further review of the Assessment revealed the above seven beds observed on two dates in April 2015 failed one or more zones of entrapment.

An interview with the Director of Care verified that they do not have a document to demonstrate what was done to mitigate the risk for those 32 failed beds. The Director of Care confirmed new beds had been ordered, but was unsure which beds had been changed and those beds had not been reassessed.

The above beds were rechecked by the Inspector and noted at this time that the risk of entrapment had been mitigated with makeshift bolsters the home had placed at the head and/or footboards. These makeshift bolsters consisted of pool noodles with a blanket wrapped around it. The actual bolsters have been ordered and will arrive mid May 2015.

An interview with the Administrator confirmed the following:
*All the beds in the home had been re-checked by the home's staff and all gaps and potential risks had been mitigated with makeshift bolsters.
*Bolsters have been ordered. The makeshift bolsters will be replaced in approximately

two to three weeks.
*The home will be revamping their bed assessment document and will be re-entering all the information to make sure it is accurate and representative of the bed and bed systems currently in place for each Resident. (520) [s. 15. (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 bed rails are used, (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 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 has failed to ensure that the resident-staff communication and response system can be easily accessed by residents at all times.

Observation revealed an identified Resident was alone in their room sitting in a reclined chair. The call bell was noted to be clipped to the pillow at the head of the bed and not within reach of the Resident. The Resident was non ambulatory.

Interview with a Registered Staff Member confirmed that the Resident's chair was in a position that would not allow them to reach the call bell. She/he then moved the Resident into the front lounge area so the Resident could be easily observed.

A second observation within a short period of time revealed the Resident had been returned to their room and their reclined chair was placed by the window. The call bell was again not within reach of the Resident.

Interview with the Director of Care who came to the Resident's room confirmed the call bell was not within reach of the Resident and that it was the home's expectation that the resident-staff communication and response system would be easily accessed by residents at all times. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident-staff communication and response system can be easily accessed by residents at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident was immediately reported to the Director.

An interview with an identified Resident revealed that on a specified date a Registered Staff Member had administered a treatment in a rough manner which was painful. After the treatment the Resident's symptoms escalated which resulted in their admittance to the hospital for a three day period for assessment, treatment, and observation.

Interview with the Director of Care revealed that she learned of the incident from the Resident when they returned from the hospital. The Director of Care informed the Administrator of the incident by phone later that same evening.

The Administrator and the Director of Care interviewed the identified Resident about the details of the incident. It was concluded that the treatment was administered in an improper manner.

An interview with the Director of Care revealed that she had not yet submitted a report to the Director regarding this incident.

An interview with the Director of Care and the Administrator confirmed that the treatment was administered in an improper manner which resulted in the Resident's two night hospitalization and that this should have been reported to the Director immediately. [s. 24. (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 improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident is immediately reported to the Director, to be implemented voluntarily.

WN #7: 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:
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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraining of a resident by a physical device is included in the resident's plan of care and that restraining of the resident has been consented to by the resident or if the resident is incapable, by the Substitute Decision Maker (SDM).

* An identified Resident was observed with a restraint.

* Review of the Care Plan for the Resident noted a restraint.

* Review of the Interdisciplinary Restraint Assessment and Consent Form for the Resident for the restraint revealed the form was not filled out and was not signed by the SDM.

This incomplete document was confirmed by the Director of Care. The Director of Care further verified that the restraint plan of care did not include the consent by the resident or if the resident was incapable, by the SDM. [s. 31. (2) 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 the restraint plan of care include the consent by the resident or if the resident is incapable, by the SDM, to be implemented voluntarily.

WN #8: 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 proper techniques to assist residents with eating, including safe positioning of residents who required assistance.

A Personal Support Worker (PSW) was observed standing to feed an identified Resident a snack. The PSW was approximately 12 inches above eye level of the Resident which placed the Resident at a potential choking risk. The Resident started coughing while being assisted with eating.

The PSW acknowledged that the expectation was that staff were to be seated while assisting Residents with eating.

Another Personal Support Worker was observed standing to feed another identified Resident a thickened beverage. The PSW was approximately 12 inches above eye level of the Resident and indicated that the expectation was that staff were to be at eye level to assist Residents with eating or drinking.

The PSW and a Registered Staff Member acknowledged that the Resident was at risk for potential choking.

The Nutrition Manager indicated that the expectation of the home was that staff were to be at the eye level of Residents to ensure safe positioning while assisting them with eating. [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 to ensure that proper techniques to assist residents with eating, include safe positioning of residents who require assistance, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a process to report and locate residents' lost clothing and personal items.

A review of the laundry services revealed that procedures had not been developed and implemented to ensure that there was a process to report and locate Residents' lost articles of clothing.

In an interview two identified Residents expressed concerns related to lost articles of clothing and lost personal items.

Three Personal Support Workers and a Laundry Aide indicated during interviews that there was not a formalized process to report lost clothing and personal items.

The Director of Support Services acknowledged that the home does not have a process in place to ensure accountability when personal items and clothing were reported as being lost and that they needed to develop a procedure to ensure that staff were aware of lost items. [s. 89. (1) (a) (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 there is a process to report and locate residents' lost clothing and personal items, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

Hazardous chemicals were observed in the unlocked and unattended East hall Soiled Utility Room.

The Director of Support Services confirmed the observation and indicated that the locking mechanism on the door was not working.

She acknowledged the home's expectation was that hazardous chemicals should be kept inaccessible to Residents at all times and immediately removed the chemicals from the room. [s. 91.]

Additional Required Actions:

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

WN #11: 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 has 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.

Observation with a Registered Staff Member noted that controlled substances to be destroyed were housed in a single locked container within an unlocked cupboard door in the medication room. When questioned, the Registered Staff Member stated the home considered the locked medication room door to be the second lock.

Observation with the Director of Care (DOC) verified the single lock for the controlled substances to be destroyed and noted that he/she was unaware of the requirement for controlled substances to be stored in a separate, double-locked stationary cupboard in the locked area. [s. 129. (1) (b)]

Additional Required Actions:

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

WN #12: 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 has failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use.

Observation of the medication pass revealed the Registered Staff Member left the medication cart unlocked and unattended 11 out of 11 times during medication administration and was not within eyesight of the cart.

A second Registered Staff Member verified that the cart was never locked between medication administrations and that the cart was not within sight of the Registered Staff Member most of the time. The staff member confirmed that the medication cart was usually left unlocked when within eyesight but confirmed the cart was not within eyesight during this observation period.

The Administrator also verified the unlocked medication cart. The Administrator observed and then locked the medication cart and noted the Registered Staff Member was unaware of the cart being locked by the Administrator until he/she was told.

An interview with the Registered Staff Member revealed it was standard practice to leave the medication cart unlocked as long as Registered Staff did not leave the area. The staff member confirmed that their back was to the cart numerous times and that the cart was not within eyesight at all times.

An interview with the Administrator and the Director of Care verified the expectation of the home was to keep areas where drugs were stored locked at all times, when not in use and would discuss this expectation with the Registered Staff. [s. 130. 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 all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

WN #13: 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 has failed to ensure that heights were taken annually.

Clinical record reviews for 9 of 9 Residents revealed that heights had not been taken annually.

A Registered Nursing staff member confirmed during interviews that the heights had not been taken annually.

The Administrator acknowledged that the expectation of the home was that heights were taken on admission and annually thereafter. She indicated that heights were taken for all Residents during the course of this inspection. [s. 68. (2) (e) (ii)]

Issued on this 6th day of May, 2015

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

Original report signed by the inspector.