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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 17, 2015	2015_284545_0007	O-001785-15	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE NORTHEASTERN ONTARIO INC
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE MEDEX
1865 BASELINE ROAD OTTAWA ON K2C 3K6

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

ANGELE ALBERT-RITCHIE (545), HUMPHREY JACQUES (599), JOANNE HENRIE (550), RUZICA SUBOTIC-HOWELL (548)

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 30, 31, April 1, 2, 7, 8, 9 and 10, 2015.

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, President of the Residents' Council, the Administrator, Director of Care (DOC), two Assistant Directors of Care (ADOC), Dietary Manager, Support Services Manager, Resident Program Manager, Dietitian, a Clinical Pharmacist Consultant, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Workers, (PSW), Activity Aides, one Dietary Aide, Housekeeping Aides, Maintenance Staff, one Janitor, one staffing clerk, and one nursing clerk.

The inspectors also toured residential and non-residential areas, observed several meal and snack services, reviewed several of the home's policies and procedures, reviewed the home's Admission Package, observed a medication pass including a medication room, observed recreation activities, observed exercise sessions, reviewed minutes for Residents' Council, reviewed Resident Health Care records, reviewed the Recreation Calendars, reviewed staffing schedules, reviewed food service documentation, reviewed cleaning schedules, and reviewed maintenance schedules and minutes and observed delivery of Resident care and services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **4 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 3 (1)

4 in that the licensee did not ensure the right to the resident to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Resident #012 is diagnosed with a specific medical condition, goes out of the home several times per week and is followed by the Dietitian as a high nutrition priority. The Resident can answer questions with a nod of the head indicating "yes" or "no". According to the Plan of Care the Resident should be provided with assistance with feeding at a specific time on 3 specific days each week as required and be in the home's front entrance by 30 minutes later.

As per section 71 (4) of the legislation, the licensee shall ensure that the planned menu items are offered and available at each meal and snack.

Upon review of Resident #012's most recent plan of care, it was indicated that the Resident was prescribed a specific diet, low potassium, high protein. Staff were directed to ensure the early meal was provided at a specific time, the Resident was provided assistance with feeding, and to ensure that the Resident was brought back to the unit when returning to the home. It was also indicated to notify the Resident's spouse, if not with the resident, to reassure the Resident had returned to the home.

On April 2, 2015 at 11:00, the Inspector observed PSW #S113 assisting Resident #012 eating an egg salad sandwich on white bread. The PSW indicated that the Resident did not eat the green salad as the Resident didn't like salad and that dessert was never made available or offered at mealtime on treatment days.

During an interview with the Dietary Manager on April 2, 2015 she indicated that Resident #012 was on a specific diet and that the Resident should have been offered baked pollock, a double boiled potato, savory carrots, white bread, peach halves or sliced turkey on white bread, creamy coleslaw and cherries in snow for lunch today. She indicated that staff on the unit called the kitchen in the morning to confirm that an early lunch was required and both options should be brought and offered to the Resident. She indicated that she thought Resident #012 was back at the home by supper time and would be offered a specific diet.

On April 2, 2015 from 11:20 to 12:08, the Inspector observed Resident #012 in the front entrance of the home waiting to be picked-up. The lunch box placed on the Resident's mobility device was observed unzipped and opened; a white envelope with the Resident's name was observed. There was no snack or other food or fluid items in the

lunch box.

During an interview with RN #S109, she indicated to the Inspector that there was no need to call the Kitchen on treatment days as the staff in the kitchen were aware of the Resident's schedule and knew to bring an early meal to the unit the those specific days each week. The RN indicated that the Resident should be offered a choice of the planned menu items, however only one plate was sent to the unit as per the Resident's specific diet. The RN indicated that the kitchen staff prepared a snack for the Resident and it was added to the Resident's lunch box before he/she left the home and returned several hours later.

During an interview with PSW #S114 on April 2, 2015, she indicated that when the Resident would be returning to the home, she would be contacting the Kitchen to have a plate of leftover chicken, pork or ham prepared for the Resident.

The Dietitian indicated during an interview on April 2, 2015 that the Resident was on a specific diet with extra protein, added that the Resident previously went to treatment with a bagged lunch but did not like it, and is now provided with a hot meal prior to leaving the home. She indicated that the Kitchen staff were expected to prepare a bagged snack with a fluid and a prescribed specific nutritional supplement for the Resident to take along.

As per section 73 (1) 7 of the legislation, the licensee shall ensure that the home has a dining and snack service that includes, at a minimum: sufficient time for every resident to eat at his or her own pace.

On April 7, 2015 at 11:00 the Inspector observed Resident #012 sitting in front of an untouched plate of four pieces of tuna sandwich and boiled zucchini. The Resident had not touched any of the food on the plate, no staff was providing assistance. PSW #S125 indicated that the Resident did not like tuna and that PSW #S123 had gone to the kitchen on the main floor to request an egg salad sandwich. PSW #125 indicated that a dessert was not offered as there was no time for it, as the Resident had to be prepared to leave the home.

At 11:20 on the same day, the Inspector observed Resident #012 in the entrance of the home waiting to be picked-up.

During an interview with PSW #S123 on April 7, 2015, he indicated that the Resident did

not want to eat the tuna sandwich; therefore he went to the kitchen to get an alternative but that he ran out of time and the Resident did not receive a meal before leaving the home. The PSW indicated that he needed to ensure the Resident was ready and brought to the main floor entrance, ready for pick-up at a specific time.

On April 7, 2015 at 11:20, the Inspector accompanied of the Dietary Manager, observed Resident #012 in the entrance of the home waiting to be picked. In the lunch box, the following items were observed: one egg salad sandwich, one Activia yogurt, one fruit cup, one ginger-ale and one specific nutritional supplement(orange flavour). After checking the content, the Dietary Manager indicated that the snack had not been prepared by the kitchen staff and that the sandwich was not fresh, she replaced it with a fresh one. She indicated she would make arrangements to meet with the spouse to review the Resident's likes and dislikes and ensure planned menu items were available and offered to the Resident at each meal and snack.

During an interview with PSW #S123 on April 7, 2015, he indicated that he picked up a few items including a nutritional supplement that were available in the unit's kitchenette to prepare a snack for Resident #012 at the request of the RPN, further indicating that the Kitchen did not prepare a specific snack for the Resident on specific days when leaving the home.

As per section 131(2) of the legislation, the licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Upon review of the physician orders on a specific date in December 2014, it was indicated that Resident #012 should have a specific nutritional supplement - 1 box (237ml) included in a Bagged Lunch for treatment appointments on three specific days each week. In the Resident's Plan of Care the Dietitian directed staff to provide the prescribed specific nutritional supplement on specific days in the Resident's bagged lunch to be taken with the Resident.

The inspector observed the lunch box attached to the back of Resident #012's mobility device on two dates, prior to the Resident leaving the home:
• April 2, 2015 at 11:20 and 12:08: the prescribed specific nutritional supplement was not found, and the only content in the lunch box was a white envelope with the Resident's name
• April 7, 2015: the prescribed specific nutritional supplement was not found; however a

different nutritional supplement (orange flavor) was found

Upon review of the Resident #012's Medication Administration Record for the month of March and April 2015, administration of the prescribed specific nutritional supplement was not found.

On April 7, 2015, during an interview with RPN #S105, she indicated that there was no prescribed specific nutritional supplement on the Resident's Medication Administration Record and this was probably the reason why the prescribed specific nutritional supplement was not provided to the Resident when he/she left the home. She indicated that each time a physician ordered a nutritional supplement, it was the responsibility of the registered staff to transcribe the order on the Medication Administration Record and for the registered staff to sign each time it was administered.

In summary, Resident #012 was not being provided with the appropriate diet, with choice at meals, with sufficient time to finish his/her meal, with an afternoon snack or with the prescribed nutritional supplement. As such, the licensee did not ensure the right to be properly fed and cared for in a manner consistent with Resident #012's needs. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that Resident #012 is properly fed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system be easily seen, accessed and used by residents, staff and visitors at all times.

Inspector #550 observed that Resident #008's call bell was not within reach in his/her room. In this room, both beds were placed lengthwise against the wall. The head of the bed of Resident #008 was adjacent to the foot of the bed of the other resident and both beds were separated by a privacy curtain. The call bell of Resident #008 was attached to the bed rail of the other resident's bed and was hanging between the wall and the bed rail. RPN staff #S107 indicated to Inspector #550 Resident #008 was able to use his/her call bell if he/she needed assistance from staff.

Inspector #548 observed that Resident #016's call bell cord was wrapped around the bed side rail that was flush to the wall. The inspector was unable to get at the call bell to test the functionality as the call bell was wedged between the side rail and the wall.

Inspector #548 observed that Resident #017's call bell cord was wrapped around the bedside rail and it was wedged between the side rail and the mattress of the resident's bed. Resident #017 had to tug on the cord several times to release the push button part from between the side rail and mattress in order to access his call bell. [s. 17. (1) (a)]

2. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

On March 30, 2015 Inspector #599 observed that there was no resident-staff communication and response system in place in the main dining room on the first floor. This same was later observed by Inspector #550. This dining room was accessible to all residents at all times; not only during meal times.

On April 2, 2015, staff #S110 and #S111 indicated to inspector #599 that there was no emergency call bell system in the dining room.

During an interview, the Administrator indicated to Inspector #550 she was not aware there was not a resident-staff communication and response system in place in the main dining room on the first floor.

The Director of Care indicated to Inspector #550 there was a portable bell at the nursing station that staff would bring in the dining room during meals but she was unable to locate it at the time of interview. [s. 17. (1) (e)]

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 is easily seen, accessed and used by Residents #008, #016 and #017 in their bedrooms, staff and visitors at all times, and ensure that the resident-staff communication and response system is available in the Dining Room on the first floor, to be implemented voluntarily.

WN #3: 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. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 31 (1) in that the licensee did not ensure that the restraint by a physical device was included in the plan of care.

On March 31, 2015, Inspector #545, observed Resident #012 with a front closure seatbelt while sitting in his/her wheelchair. When asked by the Inspector if he/she could unbuckle the seatbelt, the Resident made no attempt to release it.

On April 2, 2015 the Inspector observed the Resident with a front closure seatbelt and again when asked to release it, the Resident made no attempt to release it.

Upon review of the Resident's health record, it was indicated that no restraints or devices were in use for Resident #012 at the last assessment on a specific date in January, 2015. Restraint assessments were not found. The Resident's Plan of Care was reviewed by the Inspector and indication of front closure seatbelt while in wheelchair was not found.

On April 2, 2015, PSW #S113 indicated that Resident #012 was unable to remove the seatbelt, she indicated that the seatbelt was required and applied daily to prevent the Resident from falling out of the wheelchair. The PSW asked the Resident to unbuckle the seatbelt, by showing him/her the red buckle; the Resident slightly touched the buckle with his/her fingers, however was unable to release it.

On April 2, 2015 during an interview with RN #S118, he indicated he was not aware the Resident had a front closure seatbelt. RPN #S115, indicated that she was aware the Resident had a seatbelt however she was not aware the Resident was not able to remove it. The RPN checked the Resident's health record and indicated that if the Resident had a restraint, she would have been able to locate a physician order, a consent from the Substitute Decision-Maker and monitoring by the PSW and registered staff, which she was unable to find.

On April 7, 2015, during an interview with the Assistant Director of Care (ADOC) #S124, she indicated that the physiotherapist had assessed the Resident on a specific date in January, 2015 as independent in removing the Personal Assistive Service Device (PASD)/Restraint. She indicated that she was not aware that the Resident was no longer able to remove the front closure seatbelt. The ADOC indicated that she would be initiating the Restraint Protocol for Resident #012. [s. 31. (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 restraint by a physical device is included in the plan of care for Resident #012, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 32 in that the home did not ensure that resident receive individualized personal care, including hygiene care and grooming on a daily basis.

The Resident #013 is diagnosed with dementia and other medical conditions, has an open area on a limb that is infected and has an open area elswhere, removing the dressing often and causing trauma to the skin tear, requiring staff to replace the dressing, and increasing the risk for infection.

Resident #013 was observed on March 31, 2015 eating a small piece of Reese's chocolate; later that morning the Inspector observed brown matter under the long fingernails of the Resident's right hand.

On April 8 and 9, 2015 the Inspector observed brown matter under the nails of the Resident's right hand.

Upon review of the Resident's health record, it was documented that the Resident received a bath twice weekly on two specific days, with assistance of one person as the Resident was totally dependent for bath care. In the Point-of-Care documentation system, it was documented that the Resident had received a bath on April 2, 6 and 9, 2015 but that nailcare was not provided. On April 6, 2015, it was documented that the

Resident refused nailcare.There was no documentation to indicate a reason why nailcare was not provided on April 2 and 9, 2015.

On April 9, 2015, during an interview with PSW #S149 she indicated that PSWs were expected to provide nailcare to Residents as part of bathing or showering. She indicated that each Resident were provided with their own nail clippers which were stored in the Tub Room, and orange sticks were available in the Medication Room, added that if the orange sticks were required, a second staff would go to the Medication Room with a registered staff to get one, while the first staff stayed with the Resident. PSW #S149 indicated that Resident #013 was provided a bath on day shift and she was not aware that the Resident had not received nailcare as it had not been reported to her.

During an interview with RPN #S147 on April 9, 2015 he indicated that staff were expected to do nailcare such as cleaning and cutting of the fingernails, as part of the bathing routine. After observing the Resident's fingernails, he indicated that the nails were unclean and should have been trimmed, further indicating that if the Resident would have refused the care, it would have been documented and reported at shift change.

On April 9, 2015 during an interview with the Director of Care, she indicated that direct care staff were expected to provide nailcare as part of twice weekly bath care; as well as daily care, added she would be following up as it was not acceptable.

On April 10, 2015 the DOC indicated that indeed the Resident's nails were untrimmed/unclean, and that the Resident had refused care on April 6, 2015 but had not reported it to the registered staff. She indicated that the Resident's Plan of Care had just been updated to include need for fingernail care and strategies on how to approach the Resident, as well as need for PSW to report to registered staff when the Resident refused nailcare. [s. 32.]

2. On April 1 2015, Inspector #548 observed Resident #010 to have both eyes matted with yellow crustation.

On April 9, 2015 at 2:30pm, Inspector #550 observed Resident #010 sitting in his/her wheelchair in the hallway. The resident's upper lip and both corners of his/her mouth were covered with a white creamy substance.

The care plan in place at the time of observations with a specific date in January 2015 indicated that Resident #010 required extensive assistance from staff for personal

hygiene due to decreased mobility and cognitive loss.

During an interview, PSW staff #S136 indicated to Inspector #550 that Resident #010 was dependent from staff for the activities of daily living. He indicated Resident #010 required staff to perform most and sometimes all of the tasks for him/her and that it was their responsibility to ensure the resident was clean at all times. If the resident's mouth was dirty after a snack or a meal, it was the responsibility of the PSWs to clean it for the resident as he/she was unable to do it on their own.

As such Resident #013 and Resident #010 did not receive individualized personal care, including hygiene care and grooming on a daily basis. [s. 32.]

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 Resident #013 and Resident #010 receive individualized personal care, including hygiene care and grooming on a daily basis, to be implemented voluntarily.

WN #5: 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 comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (7) in that the licensee did not ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Resident #012 was assessed as having moderate/severe cognitive impairment as per the most recent RAI-MDS 2.0 Assessment and his/her Index of Social Engagement score was 2 out of 6, indicating low engagement in activities. The Resident's preferred

activities were documented as: exercise, sports, music, spiritual or religious activities, and watching television.

Upon review of the Resident's plan of care, it was indicated that to improve the Resident's level of participation, staff were to continue to invite the Resident to all music programs, exercise and large group programs, as well as to offer smaller music therapy groups. It was also indicated to provide access to Rosary Service twice a week.

On March 31, 2015, the Inspector observed the Resident in his/her wheelchair in his/her bedroom; the television was on, however the Resident was not facing it. The inspector did not observe the Resident participate in any structured activity over the course of the Inspection.

During an interview with PSW #S112, she indicated that she rarely saw Resident #012 involved in recreation activities; added that the Resident was off-site several times per week for an extended period of time.

Upon review of the Activity Calendars for March and April 2015 and the Resident's Activity Participation Report for a period of five consecutive weeks over the months of March and April 2015, it was indicated that the Resident participated in 2 out of 14 exercise activities available to him/her, 4 out of 13 music activities available to him/her and 0 out of 3 Rosary Service and one social visit on a specific date in March 2015. It was noted during the review of the Activity Calendar that Rosary Service was offered twice monthly; however the Resident's plan of care indicated to bring the Resident to the Rosary Service twice weekly.

During interviews with Activity Aides #S126 and #S127 on April 7, 2015, they indicated that music, exercise and Rosary Service activities were not always offered to Resident #012 even on days he/she was available in the home. They indicated that if the Resident had been offered to attend and would have refused, was ill, was away or was sleeping, a note would have been documented in the Participation Report.

On April 8, 2015 during an interview with the Recreation Program Manager and Activity Aide #S129, they indicated that there was an outbreak in the home from March 19 to April 1, 2015 and that during that time all group activities were canceled, for example:
-5 exercise group activities were cancelled
-5 music activities were cancelled
They indicated that Resident #012 should have been offered social visits by one of the

Activity Aides during the Outbreak in lieu of canceled group activities, however only one social visits was offered. They confirmed that Rosary Service was scheduled only twice per month, and not twice weekly. The Manager indicated that the care set out in the plan of care in regards to Recreation was not provided to Resident #012 as specified in the plan. [s. 6. (7)]

WN #6: 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 the licensee ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Inspector #550 observed RPN staff #S138 administer a specific narcotic to Resident #019 at 8:20am. The RPN signed the narcotic on the electronic Medication Administration Record (eMAR) in PointClickCare (PCC) but she did not sign the individual narcotic count sheet. She indicated to Inspector #550 she signed the narcotic count sheet later on in the day.

On April 9, 2015, the Inspector #550 observed the Narcotics/Controlled Substances storage count to verify consistency with the drug record log. The Inspector reviewed the narcotic count on the 2nd floor South wing medication cart. Observation as follows:

-Resident #020: a specific narcotic, 13 tabs left, the count on the individual narcotic count sheet indicated 14 tabs.

-Resident #021: a specific narcotic, 19 tabs left, the individual narcotic count sheet indicated 21 tabs.

RPN staff #S139 indicated to the Inspector she did not sign the individual narcotic count sheets as she administered the scheduled narcotics. She indicated she immediately signed the eMAR following the administration but not the narcotic count sheet. All narcotics that were administered on an "as needed basis" were immediately signed in the eMAR and on the narcotic count sheet after they were administered.

Inspector #550 reviewed the home's policy titled "Narcotics and controlled drugs" that was provided by the Director of Care. The DOC later indicated to the inspector that the home did not follow Extendicare's policies regarding narcotics; that they had a contract with Medical Pharmacies and they provided the policies and procedures the home was to follow regarding medications. Inspector #550 reviewed policy #6-7 from Medical Pharmacies titled "Combined Individual Monitored Medication Record with Shift Count", revised 01/14. Procedure 4 indicated: Sign on the "Combined Individual Monitored Medication Record with Shift Count" each time a dose is administered. Include the date, time, amount given, amount wasted, and new quantity remaining.

A copy of this policy was kept in the narcotic count binder in each medication cart on each unit and was the policy staff referred to.

As such, the home did not comply with their policy and procedure regarding the documentation of narcotics and controlled substances. [s. 8. (1) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 37 (1) in that the home did not ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items; and cleaned as required.

Residents' rooms were observed on March 31 and April 1, 2015. A sink with counter space on both sides was observed outside the shared bathroom in the Residents' rooms. Residents' personal items were observed on the counter space. The following Inspectors observed personal items unlabelled and others unclean:

Inspector #545
• Room 141: two hair brushes and one black comb unclean and filled with hairs
• Room 231: one gray brush filled with hairs, one black plastic comb, one white denture brush and one blue denture cup; all unlabelled
• Room 230: one pink toothbrush in a small plastic glass and one green toothbrush in another small plastic glass; all unlabelled. One pink hair brush filled with hair and unclean

• Room 212: one large jar of petroleum jelly, one blue comb and one light blue comb/razor covered with a sticky light yellow matter, including a large amount of hairs
• Room 233: two toothbrushes on the counter by the sink, and one toothbrush in a plastic glass, one green toothbrush in a plastic basket; all unlabelled

Inspector #550
• Room 117: two toothbrushes, an open tube of toothpaste, a ziplock type clear plastic bag visibly soiled with white matter containing a toothbrush and one tube of toothpaste; all unlabelled. As well, one peach coloured hair comb with the picks visibly dirty with gray matter

• Room 139: one secret deodorant, two bars of soap in one soap dish; all unlabelled

Inspector #599
• Room 251: one urinal on top of the toilet tank in the shared bathroom, toothbrushes, one tube of toothpaste, deodorant sticks; all unlabelled. As well, one hairbrush with build-up of hair was observed.
• Room 265: one razor, one toothbrush and one hairbrush; all unlabelled
• Room 235: two denture cups, toothbrushes and toothpaste; all unlabelled. As well, one pink hairbrush with build-up of hair was observed
• Room 302: one unlabelled hairbrush with build-up of hair on the counter, one denture cup, one toothbrush, one toothpaste; all unlabelled in an unlabelled kidney basin
• Room 309: one toothbrush, one razor, one toothpaste; all unlabelled in an unlabeled kidney basis
• Room 303: one used disposable razor, one toothbrush, one toothpaste; all unlabelled

On April 10, 2015 Inspector #545 interviewed PSWs #S151, #S122 and #S133 regarding Residents' personal items. They indicated that it was their responsibility to label the Residents' personal items and to keep them clean and replace them when they were no longer in a usable state. When asked if the gray hairbrush in room 233, the blue toothbrush in room 251, the pink hairbrush in room 235 and the gray hairbrush in room 309 required cleaning, they indicated that these items had visible build-up of dirt and hairs, were unclean, with frayed bristles and should have been replaced.

During an interview with the Director of Care (DOC) on April 10, 2015, she indicated that it was the responsibility of the front line staff to check the status of the Residents' hair brushes and toothbrushes during daily care, to clean them, and to replace them as needed. The DOC indicated that the home stored new hairbrushes and toothbrushes in the Medication Rooms on each floors and that it was the responsibility of the registered staff to dispense new personal items to Residents as required. After checking the status of the hairbrushes found in rooms 251 and 230, she directed staff to replace them immediately. [s. 37. (1)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure it responds to Resident's Council within 10 days of receiving the advice from council.

On April 1, 2015 during an interview the President of Resident's Council indicated that issues and concerns were raised at meetings. The President indicated that there were several issues raised at meeting on March 9, 2015, however he/she was not sure what action had been taken in response to those concerns.

It was noted from a record review that there were several concerns raised on March 9, 2015 by Resident Council at their monthly meeting.

The concerns were documented as follows:
-Cleanliness of furniture on the 1st floor. It appeared there was a resident who was constantly spitting in the plants and on the furniture, blowing his/her nose with inappropriate items and leaving those items behind. It had been witnessed that this resident was removing clothing from the lost clothing rack in the basement.

-Could night staff be respectful of residents who are sleeping when they come in to check or provide care for the roommate.

-The 1st floor had been painted but when were the baseboards going to be put back on.

-It was noted that some residents were lying down on the couch on the 1st floor. Could they be encouraged to go the their rooms if they were tired.

-The residents were wondering if they would be receiving a rebate from Roger's Cable due to the loss of channels.

On April 2, 2014 the Inspector interviewed Activity Aide #S107 who acted as the

facilitator between the home and the council. Staff #S107 indicated that she transcribed all of the Resident's Council concerns on a form (Response Form) and forwarded the document and meeting minutes to the Administrator within 2 to 7 days of the monthly meetings.

On April 2, 2015 during an interview, the Administrator confirmed that the form (Response Form) with the Resident's Council concerns were received within 2-5 days' time of the council meeting and she distributed the issue to the responsible person (Head of the department) for response or action. The Administrator confirmed she reviewed each of the responses or actions taken and forwarded them to #S107 for distribution at the next council meeting. The Administrator indicated that she was not aware that it was required to respond to Resident's Council in writing within 10 days of receiving a concern.

At the time of the inspection the administrator informed the inspector #548 that they are making changes to the home's process to ensure they respond to Resident's Council in writing within 10 days of concerns raised.

As such, the Licensee has failed to ensure it responded in writing to Resident Council within 10 days of receiving advisement from council. [s. 57. (2)]

WN #9: 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. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 78 (2) h in that the licensee did not ensure that the package of information includes, at a minimum, the name and telephone number of the licensee.

Upon review of the Admission Process Checklist, in item 2 (i) where it asks the home if the admission package of information included the name and telephone number of the licensee, the item was left unanswered.

The Inspector reviewed the home's Information Package and on page 1, section I, it was indicated that "A licence to operate the Home has been issued pursant to the Long-Term Care Act, 2007 to the following licensee: Extendicare Medex: 1865 Baseline Road, Ottawa, Ontario, K2C 3K6, Telephone: 613-225-5650".

During an interview with the Administrator on April 8, 2015 she indicated that the name and licensee telephone number were not included in the Information Package given to Residents' and Families, that the information provided was the home's name and telephone number, added that she was in the process of updating the package and would make the change. [s. 78. (2) (h)]

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

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

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

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 87 (2) (a) in that the home did not ensure that procedures are developed and implemented for cleaning of the home, including,
i. resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
ii. common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

On March 31, 2015 Inspectors #545, #548 and #599 observed soiled privacy curtains and draperies in the following Residents' rooms and again on April 9, 2015 by Inspector #545:

-Room 242: three large brownish soiled areas measuring approximately 3 feet in length and several small brownish areas on the privacy curtain separating bed 1 and bed 2

-Room 230: several large and small pink and black soiled areas, one of the large soiled area with pink matter measured approx. 6 to 8 inches in length on the privacy curtain separating bed 1 and bed 2

-Room 365: several reddish brown soiled areas on the right side drapery covering the

window

Upon review of the home's policy, provided by the Support Services Manager, titled: Privacy Curtains and Draperies Sample, HKLD 05-03-06, Appendix 7, it was documented that privacy curtains and draperies in Residents' rooms needed to be inspected routinely for stains, soil, missing hooks or repairs, to send them to the laundry for cleaning or mending and inform the laundry if needed them back the same day or could be re-hung immediately to dry in place.

During an interview with Housekeeping Aide #S143 on April 9, 2015, she indicated that it was her responsibility to inspect the privacy curtains as part of the daily cleaning of each Resident's room. Accompanied of the Inspector, Staff #S143, observed the privacy curtains in room 230 and 242 and indicated that both privacy curtains were soiled and required immediate cleaning. She indicated that she had not noticed the large soiled areas on both these privacy curtains.

During an interview with the Support Services Manager on April 9, 2015, he indicated that the cleaning of the privacy curtains and draperies was done upon a Resident's discharge, coming out of outbreak, when soiled or at least once a year. He indicated that the housekeepers needed to communicate to the janitor if any curtains were soiled, or heavily soiled and therefore needed to be washed. He further stated that the Floor Care Communication Board was used for staff to document any rooms that required curtains cleaned.

The inspector reviewed the Communication Board with the Support Services Manager on April 9, 2015 and no privacy curtains or draperies were documented on the board. When asked to come with the Inspector to observe rooms 230 and 242, he indicated that the curtains had already been taken down and brought to the Laundry for cleaning by the housekeeping staff.

Accompanied by the Inspector on April 9, 2015, the Support Services Manager observed the draperies in room 365 and he indicated that they were heavily soiled and would have them cleaned immediately. [s. 87. (2) (a)]

2. The licensee has failed to comply with O.Reg 79/10 s. 87 (2) (d) in that the home did not ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

Each time Inspector #545 used the North stairwell on March 31, April 1, 2, 7, 8, 9 and 10, 2015 at different times of the day between 08:00 and 17:00, an offensive lingering odor was observed at the end of the North hallway, on the 2nd floor.

The home's policy entitled: Housekeeping and Laundry Services - Odors, Policy Reference # HKLD-05-03-08, dated September 2013 on April 10, 2015. The policy was reviewed by the Inspector; and under the section Procedure it indicated to:

(1) Identify the source of the odour issue. It is recommended to use Appendix 1 as a guide.

(2) If unable to identify source of odour, review the area with odour issues at various times of the day to establish if the odour is ongoing.

(3) Investigate the cause of the unacceptable lingering odour through looking at process/procedure/systems.

(4) If required, repeat review of the area in 1-2 weeks to identify change and/or repeat investigation if change was not successful.

There was no indication of procedures for addressing incidents of lingering offensive odours in the Policy provided to the Inspector.

Upon review of the Carbolization Schedule Second & Third Floors North, for the period the months of February and March 2015, it was indicated that a specific room on the 2-North Hallway was carbolized once and a second specific room was carbolized three times.

On April 10, 2015 during an interview with PSW #S151, RPN #S104, they indicated that the lingering offensive odor had been an issue for approximately 4 to 6 months. They indicated that the use of lava rocks had been trialed but that it was not effective to eliminate the offensive odor. RPN #S104, indicated that an odor eliminator spray was used regularly, however it had been removed from the shared bathroom between two specific rooms in the 2-North hallway the previous week, added that the home had a no-scent policy and that sprays were not allowed, however the sprays were made available and the staff used them when the odors were not being managed.

RPN #S104 indicated on April 10, 2015 that Resident #022 and Resident #023 were

known to urinate on the floor and that it was possible that the urine had seeped under the tiles as no products seem to eliminate the offensive lingering odors from these rooms, including the shared bathroom.

During an interview with Housekeeping Aide #S143 on April 10, 2015 she indicated that she used a product called: High Performance Ultra Concentrated Neutral Floor Cleaner, diluted from the QC QuickClick dispenser to clean the floors. To manage lingering offensive odors, Staff #S143 indicated she used Odor Counteractant, a diluted product she poured into a spray bottle, labeled QC Laundry Fresh Air Freshener. She stated that she sprayed this product directly on the privacy curtains and in the air, added that when used at the end of the 2-North hallway and in two specific rooms in that area, including the shared bathroom, but this product was not effective. She stated that she had in the past, used a personal Mist to help manage the odor as she was concerned that Residents and especially visitors would complain. Staff #S143 indicated that she was not aware of the home's Lingering Offensive Odor Policy, as it was not included in her daily routine manual, which she showed the Inspector.

The Inspector interviewed Maintenance Staff #S153 on April 10, 2015, who indicated that a Vaportek Neutral EZ Disk 34-7600 dispenser was installed on the wall between bed 1 and 2 in one of the two specific rooms in the 2-North hallway, added that he could not indicate the date of installation or when the disks were changed last. After opening the dispenser, staff #S153 showed the Inspector that two disks were in place and that a fresh odor was still present. He indicated that he would change them and add a third disk to help reduce the lingering offensive odor.

Accompanied by the Inspector on April 10, 2015, the Administrator indicated she observed an offensive lingering odor at the end of the North hallway on the 2nd floor, in a specific room and in the shared bathroom. She indicated that the odor procedures as per the home's policy were not implemented to address the lingering offensive odor. [s. 87. (2) (d)]

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 failed to ensure that 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 (e.g. expiration dates, refrigeration, lighting).

On April 8, 2015 Inspector #550 observed the medication cart on the 2nd floor south wing. Inside the narcotic drawer, inspector observed two envelopes; one envelope was labelled with a resident's name and contained bus tickets for this resident and the other envelope was labelled with another resident's name and contained $20.

On April 9 2015, Inspector #550 observed the medication cart on the 2nd floor north wing. Inside the 4th drawer of the medication cart inspector observed a hearing aid, rosary beads, a nail clipper, a toenail nipper and an envelope labelled with a resident's name which contained a pair of broken glasses.

Inspector #550 observed the medication cart on the 3rd floor west wing. Inside the 3rd drawer of the medication cart, inspector observed 3 packs of disposable razors labelled with a resident's name, a small plastic bin containing a paring knife and nail nippers. In the bottom drawer, there was a carton of cigarettes belonging to a resident.

RPN staff #S105 indicated to Inspector #550 these items are stored in the medication cart for safekeeping for the residents. [s. 129. (1) (a)]

WN #12: 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. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a member of the registered nursing staff permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical only if:

(a) The staff member has been trained by a member of the registered nursing staff in the administration of topicals

(b) The member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and

(c) The staff member who administers the topical does so under the supervision of the member of the registered nursing staff

During an interview, PSW staff #S134 indicated to Inspector #550 PSWs applied prescribed creams to residents. She indicated she had been working in the home for 2 years now and she had been applying topicals to residents on a regular basis. She indicated she thought she received training on how to apply topicals during her orientation when she started her employment at the home but was unsure.

PSW staff #S135 indicated to Inspector she applied prescribed topical creams to residents. She indicated she had been working at the home for 6 years and had never received any training by registered staff on how to apply topical creams.

During an interview with RPN staff #S105 she indicated to Inspector #550 PSWs were not permitted to apply prescribed topical creams to Residents. She further indicated being aware that some PSWs did apply prescribed topicals to residents but they were not supposed to as this task was assigned to Registered staff only.

The Director of Care indicated to Inspector #550 during an interview it was the home's expectation that only PSWs who had received training from Registered staff were permitted to administer topicals to Residents. She indicated the training on how to apply topicals was not done during orientation, it was done at a different time. She also indicated the topicals were now included in the Treatment Administration Records (TARS) so registered staff could do the application themselves. [s. 131. (4)]

Issued on this 1st day of May, 2015

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

Original report signed by the inspector.