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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 20, 2017	2017_561583_0015	019316-17	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE MISSISSAUGA
855 JOHN WATT BOULEVARD MISSISSAUGA ON L5W 1G2

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

KELLY HAYES (583), NATASHA JONES (591)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): August 16, 17, 18, 21, 22, 23, 24, 25, 28.

During the course of this inspection, the following additional inspections were conducted:

Complaint Inspections: Log #003664-17, related to medication administration; log #008987-17 and #016937-17 related to personal support services; log #017467-17, related to allege unsafe transfer and personal care and log #018936-17, related to alleged staff to resident abuse.

Critical Incident System (CIS) Inspections: Log #003661-17, related to medication administration; log #004774-17 and 019775-17, related to alleged staff to resident abuse and log #007739-17, related to falls.

On Site Inquires: Log #002544-17 and #010924-17.

Follow Up Inspections: Log #004235-17, related to reassessment and review of the plan of care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Social Worker (SW), Program Manager, Environmental Manager, Maintenance Supervisor, RAI MDS Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and Residents and Residents` Family Members.

During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home, and reviewed relevant documents including but not limited to meeting minutes, policy and procedures, menus and clinical health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2017_551526_0004	583

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

In August 2017, in an interview with resident #004 it was asked "Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?". The resident responded no, sharing a specified example of when they waited unattended for a specified period of time before staff came back to provide them assistance.

On an identified date in August 2017, the care plan was revised and specified interventions were added related to toileting.

A review of the physical functioning and structural problems assessment, identified resident #004 required extensive assistance from two staff. The plan of care identified that a specified intervention would not be effective for the resident and they would be at risk of harm if left unattended during toileting.

In an interview with ADOC in August 2017, it was confirmed that the care plan interventions put in place on an identified date in August 2017, were not based on the

assessed needs of the resident or the resident's preferences. [s. 6. (2)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A review of resident #016's clinical health records indicated the resident had a known history of falls with specified injuries prior to their admission. The resident sustained two falls in the home in 2017, one of which resulted in an injury.

A review of the resident's most recent resident assessment instrument (RAI) minimum data set (MDS) quarterly assessment and a review of the resident's plan of care revealed that there were multiple areas of conflicting assessments and different directions as to what was required for resident #016's care.

Areas where the assessments and care plan were not integrated and consistent and did not complement each other included:
Bed rails, use of assistive devices and medical devices, level of assistance required for transfers, mobility and toileting.

In interviews, PSWs #173 and #201, and registered staff #119 confirmed the level of assistance the resident required for transfers, mobility, toileting and the use of assistive devices and mechanical devices were not reflective of what the resident required.

In interviews, the Program Manager and ADOC confirmed staff did not collaborate with each other in the assessment of resident #016, and the assessments were not integrated or consistent with and complementing each other.

This area of non-compliance was identified during a critical incident inspection, log #007739-17, conducted concurrently during this inspection. [s. 6. (4) (a)]

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

A) Observations of resident #016 in August 2017, revealed a specified device, required for use by the resident had not been activated as required.

A review of resident #016's clinical health records identified them as a high risk for falls related to a previous history of falls with injury. In addition they had two falls over a two month period since admitted to the home, one of which resulted in an injury.

A review of the two post fall assessments, included the use of a specified device as a falls prevention strategy. A review of the resident's current written plan of care, last reviewed, directed staff to ensure that the specified device was in place when the resident was in an identified location, and that it was working.

In an interview, PSWs #173 and #201 indicated resident #016's device had not been activated as required. They further confirmed the resident was able to mobilize independently if they chose, and often forgot to ring the bell for assistance. The staff confirmed the device should have been activated.

In interviews, the Program Manager and the ADOC confirmed the device should have been activated, and further confirmed the staff did not provide care to the resident as per their written plan of care. (591)

This area of non-compliance was identified during a critical incident inspection, conducted concurrently during this inspection.

B) A review of resident #013's care plan identified they required two staff to complete all aspects of positioning. The physical functioning and structural problems assessment completed, identified resident #013 required two person assistance for all activities of daily living. During an interview with PSW #178 on an identified date 2017, and through documented staff interview notes completed by the home on on an identified date in 2017, it was identified that care was not provided as per the plan of care. PSW #172 independently repositioned the resident in bed and positioned an assistive device under the resident prior to PSW #178 arriving to provide assistance.

In an interview with the DOC in August 2017, it was confirmed that resident #013 was not positioned by two staff as specified in the plan. (583)

This area of non-compliance was identified during a complaint inspection, conducted concurrently during this inspection. [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 care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident; to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and consistent with and complement each other and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

A review of resident #014's clinical health records revealed they were administered the wrong medication and treatment on an identified date in 2017.

A review of the home's investigation notes indicated that on the day of the incident, the nurse practitioner (NP) had written an order for the medication and treatment to be administered to resident #019. The registered staff retrieved the medication and treatment, prepared it, and administered it to resident #014. Details of the medication error were identified and reviewed.

A review of resident #014's medication administration record (MAR) and electronic medication administration records indicated the above mentioned medications were not prescribed for the resident. A review of resident #019 MAR and eMAR revealed the NP had written an order for the above mentioned medications to be administered to resident #019.

A review of the home's policy #RC-06-05-07, titled "Medication Management", last updated June 2016, directed registered staff to ensure the resident information on each medication corresponded with the resident's MAR and eMAR prior to administering the medication; to ensure two resident identifiers prior to administering medications; and administer medications following the eight rights of medication administration: Right resident, right drug, right dose, right time, right route, right reason, right response, and right documentation.

In an interview, the DOC and the ADOC confirmed resident #014 was administered the wrong medication and treatment by the registered staff.

This area of non-compliance was identified during a complaint inspection, and a critical incident system inspection conducted concurrently during this inspection. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug had been prescribed for the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Interviews with the complainant, a review of the home's internal investigation notes and a review of resident #014's clinical health records revealed that on an identified date in 2017, they were administered an incorrect medication and treatment by a registered staff.

A review of the progress notes and a "Medication Incident Report" completed by the registered staff on the day of the incident indicated they documented the error in the administration of the medication to resident #014, but did not document the error in administering the treatment. A review of a statement provided by the physician indicated the registered staff notified them on the day of the incident that resident #014 was accidentally given the identified medication, but did not inform them the resident received another resident's medication and treatment.

A review of the home's policy #RC-06-05-09, titled "Medication Incident and Reporting", last updated June 2016, indicated immediate action should be taken in the event of an incident/adverse drug event by notifying the Physician/Nurse Practitioner for treatment directions, and medication incident/adverse drug events should be communicated and documented.

In an interview, the DOC and ADOC confirmed a registered staff member failed to document the immediate actions taken to assess and maintain the resident's health; and failed to report the incident to the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

This area of non-compliance was identified during a complaint inspection, and a critical incident system inspection, conducted concurrently during this inspection. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee failed to ensure that the resident's plan of care was based on an interdisciplinary assessment of the resident's continence, including bladder and bowel elimination.

A review of resident #002's most current RAI MDS assessment indicated the resident was frequently incontinent of both bowel and bladder. A review of resident #002's current written plan of care, indicated they were frequently incontinent of bladder; however, the plan did not include their bowel continence status. Interviews with PSW #240 and registered staff #152 indicated the resident was frequently incontinent of both bladder and bowels.

A review of policy #RC -14-01-01, titled "Continence Program", last updated Feb 2017, indicated to ensure all residents who were incontinent had a care plan that was reflective of their current functional status.

In an interview, the RAI Coordinator confirmed resident #002's written plan of care did not include an assessment of their bowel continence. [s. 26. (3) 8.]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

During observations of resident #016 on two dates in August 2017, specified bed rails were engaged while the resident was in bed. The resident confirmed in an interview that they used the rails to assist them with positioning in bed. In interviews, PSWs #173 and #201, and registered staff #119 indicated resident #016 used specified bed rails to assist them with positioning in bed, and identified the bed rails as personal safety assistive devices (PASDs).

A review of the resident's current written plan of care, did not include the use of bed rails. In interviews, registered staff #119, the Program Manager and the Assistant Director of Care (ADOC) confirmed the use of bed rails identified as a PASD by resident #016, were not included in the resident's written plan of care.

This area of non-compliance was identified during a critical incident inspection, conducted concurrently during this inspection. [s. 33. (3)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

The licensee failed to ensure that each resident of the home had his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

Observations of resident #002 revealed they were sleeping in their chair after breakfast for three consecutive days. In an interview, resident #002 stated the staff wake them too early for care, they would prefer to sleep in later, and sitting for lengthy periods in their chair was fatiguing. The resident further confirmed they did not usually sleep well during the night.

A review of the resident's most current MDS assessment, indicated the resident had difficulty sleeping or a change in their usual sleep pattern. A review of the resident's most current written plan of care, did not include resident #002's sleep and rest pattern.

In interviews, the RAI Coordinator and ADOC confirmed resident #002's desired rest routine was not supported. [s. 41.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

The licensee failed to ensure that strategies were developed and implemented to meet the needs of residents who could not communicate in the language(s) spoken in the home.

In an interview with resident #009 in August 2017, with a translator, it was identified that the resident was not always offered their choice and preferences related to care provided due to a language barrier. The resident shared they felt isolated and lonely.

A review of the resident's care plan identified the resident had a language barrier and the goal was that staff would communicate effectively with the resident. Three specified interventions for communication were included in the resident's plan of care.

The activity calendar located in the resident's room was attached to the wall and was in small print in English and the resident could not read it.

In an interview with registered staff #136 it was confirmed that the three identified interventions for communication were not implemented. It was shared front line staff did not have a tool to communicate daily preferences/choice or to explain what personal care was needed or going to be provided as a tool had not been created by the home

In an interview with the Program Manager in August 2017, it was confirmed that strategies were not implemented to meet resident #009's communication needs. [s. 43.]

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 :

The licensee failed to ensure the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

Resident #002's RAI MDS assessment completed on an identified date in 2017 and indicated the resident was bowel continent, and had frequent bladder incontinence. The most current MDS assessment, completed three months later, indicated the resident was frequently incontinent of both bowel and bladder.

Interviews with PSW #240 and registered staff #152 indicated the resident had deteriorated, and was frequently incontinent of both bladder and bowels. The registered staff confirmed a continence assessment had not been completed when resident #002 had a change in their condition.

A review of policy #RC -14-01-01, titled "Continence Program", last updated Feb 2017, indicated a continence assessment should be completed using a clinically appropriate tool with any deterioration in continence level. A review of the resident's clinical health records revealed a continence assessment was not completed.

In an interview, the RAI Coordinator confirmed a continence assessment should have been completed when there was deterioration in resident #002's level of continence. [s. 51. (2) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the program included the communication to all residents of a schedule of recreation and social activities that were offered during days, evenings and weekends and the assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently.

In an interview with the resident #009 in August, 2017, the resident was asked, "Do organized activities meet your interest?" and the resident responded "No.". During the interview it was shared that the resident was not aware of what was offered in the home.

According to the care plan interventions staff were to encourage and assist resident #009 to participate in specific activities that the home identified where of interest to the resident. A review of the residents Multi-Day Participation Report over a three month period in 2017, showed the resident was not offered and did not participate in the identified activities they expressed they would like to attend.

In an interview with the Programs Manager in August 2017, it was also confirmed that the resident was not offered to participate in the identified activities that were of interest to the resident over the past three months. [s. 65. (2)]

WN #10: 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: 3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had a dining service that included, at a minimum, meal service in a congregate dining setting unless a resident's assessed needs indicated otherwise.

Progress notes documented on an identified date in 2017, by registered nursing staff #102 identified resident #013's supper meal service was provided in their room and the resident received one person assistance with feeding as directed in their plan of care. The documented assessment noted the resident ate their full meal with no signs of intolerance. In an interview with registered staff #102 and PSW #178 on an identified date in 2017, it was shared the resident was positioned at 90 degrees prior to being fed and they were monitored during the meal service.

In an interview with the ADOC and DOC on two identified dates in August, 2017, it was identified that there was a delay in the care provided to resident #013 due to staffing. It was confirmed that staff were unable to assist the resident up from their bed and get them to the congregate dining area for the supper service on an identified date in 2017.

This area of non-compliance was identified during a complaint inspection, conducted concurrently during this inspection. [s. 73. (1) 3.]

WN #11: 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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

During Observations on three specified dates in 2017 of two identified rooms on different units revealed very strong smell of urine in the rooms and in the corridor near the rooms.

In an interview, PSW #178 indicated that room A had an on-going smell of urine, caused by a resident's incontinence and behaviours. In an interview, PSW #174 and registered staff #141 indicated room #B smelled of urine, and revealed the smell was coming from an identified resident's mattress. They confirmed the resident was incontinent and urine was likely leaking into their mattress, causing the odour, and further confirmed they did not report the offensive odour to the EM. In an interview, the Environmental Manager (EM) confirmed that room #A had an on-going smell of urine, and several intervention including chlorine on the floor, and deep cleaning with chemicals for the resident's chair and mattress; however, the air excavator to circulate air in the room was located in the bathroom, but the resident refused to keep the door open. The EM was not aware of the foul odour in room #B.

The home did not ensure procedures were developed and implemented to eliminate lingering offensive odours in the above mentioned home areas. [s. 87. (2) (d)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart, i. that was used exclusively for drugs and drug-related supplies.

Observations of the medication carts on two units on an identified date in August 2017, revealed non-medication related items were stored in the carts including a pair of glasses, a gold colored watch and hearing aids belonging to residents in the top drawer of one unit, and two pairs of resident's glasses in the top drawer of the other unit cart

In an interview, registered staff #152 confirmed the items mentioned above belonged to residents and were stored in the medication carts for safe keeping.

In interviews, the DOC and ADOC confirmed the above mentioned medication carts were not used exclusively for drugs and drug-related supplies. [s. 129. (1) (a)]

Issued on this 21st day of September, 2017

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

Original report signed by the inspector.