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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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
Jul 13, 2017	2017_565612_0012	009422-17	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 YORK
333 YORK STREET SUDBURY ON P3E 5J3

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

SARAH CHARETTE (612), ALAIN PLANTE (620), LISA MOORE (613)

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): June 5-9, and 12-16, 2017.

Additional logs inspected during this RQI included:
- One follow up, compliance order (CO) #001, related to s. 19 of the LTCHA, 2007, failure to protect residents, from Inspection #2017_565612_0004.

- Three complaints, one related to an inappropriate discharge, one related to keeping personal items in the home and one related to the care of a resident in the home.

- Eight Critical Incident (CI) reports the home submitted to the Director, two related to residents who fell and six related to the alleged abuse of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Registered Dietitian (RD), Personal Support Workers (PSWs), Resident Assessment Instrument (RAI) Coordinator, Dietary Manager, Food Services Supervisor, Support Services Supervisor and residents and their family members.

The Inspectors also conducted a daily walk through of resident care areas, observed the provision of care towards residents, observed staff to resident and resident to resident interactions, reviewed the homes policies, procedures and programs, reviewed staff personnel files, reviewed resident's health care records and the home's investigation files.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
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
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **10 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. 19. (1)	CO #001	2017_565612_0004	613

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

Findings/Faits saillants :

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

Inspector #613 reviewed a Critical Incident (CI) report that was submitted to the Director on a specific date. The CI report described that resident #015 had a fall that resulted in a injury.

A review of the home's CI report investigation file identified that PSW #118 had assisted resident #015 with an activity of daily living and then left the resident unattended to retrieve an item. When PSW #118 returned to the resident, they found resident #015 on the floor. As stated in the investigation notes, PSW#118 reported that the resident was unattended for a specific amount of time.

A review of resident #015's care plan at the time of the incident revealed that the resident required a specific level of assistance from staff.

During an interview with RPN #116, they informed the Inspector that if the care plan identified the specific level of assistance was required from staff then staff were required to stay with the resident while providing assistance with the activity of daily living and should not have left them unattended.

During an interview on June 9, 2017, with the DOC, they confirmed that PSW #118 should not have left the resident unattended. [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 that the care set out in the plan of care is provided to resident #015 as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Inspector #613 reviewed a CI report that was submitted to the Director on a specific date. The CI report described alleged staff to resident neglect. The CI report stated that the DOC had received a written letter from RPN #138 describing concerns regarding the failure of PSW #137 to provide personal care to resident #012. RPN #138 stated in the letter that they noticed a pattern of inaction from PSW #137 to provide the appropriate care when they worked with resident #012. The CI report identified that at the start of several shifts, RPN #138 had found the resident with the appearance of not having received personal care.

A) A review of the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" last revised April 2016, identified that any employee or person who becomes aware of an alleged suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager or if unavailable to the most senior Supervisor on shift at the time. All staff must protect the rights of each resident entrusted in their care.

The investigation notes revealed that there were several instances where staff had not followed the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting".

i) Sometime prior to the specific date, RPN #138 informed RPN #136 of their observations of resident #012 and concern for care not being provided. RPN #136 reported the concerns of neglect to RN #135. The RN #135 did not report the alleged neglect to the on call manager. RPN #138 had not reported to the RN who worked the same shift as RPN #138.

ii) On the specific date, RPN #138 informed RPN #136 in writing of their observations, but had not informed the RN working the same shift as RPN #138, of their concerns of neglect. RPN #136 had provided direction to the care staff working their shift, but did not inform the RN working the same shift of the concerns that were bought to their attention regarding neglect of care for resident #012.

iii) On another specific date, RPN #138 had found resident #012 again without having personal care provided, they did not report their concern of neglect immediately to the Administrator/designate/reporting manager or if unavailable to the most senior Supervisor on shift at the time. A written letter was completed by RPN #138 and provided to management the next day.

During an interview with the DOC, they revealed that the RPN was required to report to the RN (Nurse in Charge), who was responsible to ensure the resident's safety and was responsible to notify the manager on call, after business hours. The DOC confirmed that for each occurrence, RPN #138, RPN #136 and RN #135 had not followed the home's policy for reporting, when they had suspected neglect. The DOC stated that RN #135 should have reported to the on call manager.

During an interview on June 15, 2017, with the Administrator, they confirmed that staff had not followed the home's policy for reporting immediately and that each occurrence should have been reported to the manager on call.

B) According to the Long-Term Care Homes Act, 2007 O. Reg 79/10, neglect is defined as the failure to provide a resident with the treatment, care services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

A review of the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect Program" last revised April 2016, identified that Extendicare was committed to providing a safe and secure environment in which all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times. Any form of abuse by any person interacting with residents, where though deliberate acts or negligence would not be tolerated. All staff must protect the rights of each resident entrusted in their care.

A review of resident #012's care plan identified that the resident required a specific level of assistance from staff for care but the care plan did not identify that resident was resistive to care or refused care.

During interviews with PSW #117 and PSW #118, they verified that the resident was not resistive to care nor did they refuse care.

A review of resident #012's health care record identified that a head to toe assessment was completed after the incident had occurred and indicated that resident had a specific skin impairment.

During an interview on June 9, 2017, with the DOC, they stated that there was evidence to suggest that PSW #137 had neglected to provide care to resident #012 and that they had been disciplined as a result. The DOC stated they were unsure if resident #012's specific skin impairment was a result of not having been provided care, but it could have been related.

During an interview on June 15, 2017, with the Administrator, they confirmed that PSW #137 had neglected to provide the appropriate care to resident #012. [s. 20. (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 written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked areas or stored in a separate locked area within the locked medication cart.

On June 5, 2017, at 0841 hours, Inspector #620 observed a medication cart that was unlocked and unattended in a common area of the home. Two residents passed by the unlocked medication cart during the Inspector's observation and three staff members walked by the unlocked and unattended medication cart. At 0847 hours, an RPN returned to the medication cart and locked it.

On June 6, 2017 at 1347 hours, Inspector #612 observed through the window in the medication room on a specific floor, that the two medication carts stored in the room were left unlocked. The door to the medication room was locked.

Inspector #613 interviewed RPN #116 and RPN #120, who both verified that that registered staff were to ensure that medication carts were locked when out of a registered staffs view. RPN #120 informed the Inspector, that the medication carts stored in the medication room were not normally locked.

A review of the home's policy titled, "The Medication Storage" dated February 2017, identified that medication stored in a medication room must be locked at all times with the keys in the possession of the designated nurse. When medication carts were used to store all currently required medications, carts were to be locked at all times when not attended by the nurse. Narcotics and controlled (monitored) medications were to be locked (ie. in the cart) separated from other regular medications and locked in the medication room (these medications were to be double locked in the cart or cabinet in a locked room ie. triple locked).

During an interview on June 9, 2017, with the DOC, they confirmed that the medication carts were to be kept locked at all times, when they were out of the registered staffs view. [s. 129. (1) (b)]

Additional Required Actions:

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

WN #4: 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 home was equipped with a resident-staff communication and response system that was easily seen, accessed and used by residents, staff and visitors at all times.

Inspector #613 reviewed a CI report that was submitted to the Director on a specific date. The CI report described an allegation of staff to resident neglect. The CI report stated that on the specific date, resident #014 had reported to PSW #130 that they did not have specific care provided to them through the night and that they did not have their call bell within reach. Resident #014 was unavailable for interviews or observation during the inspection.

Inspector #613 reviewed resident #014's care plan in place at the time of the incident and was unable to find any interventions related to the specific care required through the night and positioning of the call bell.

A review of the home's internal investigation revealed that PSW #132 had left the call bell for resident #014, in an area which was not easily seen, accessed or used by the resident.

During an interview on June 9, 2017, with the DOC, they stated that resident #014 had received the specific care through the night, however, if they required additional care, they were not able to ring for assistance as the call bell had been placed out of their reach. The DOC confirmed that call bells were to be easily seen, accessed and used by the resident at all times. [s. 17. (1) (a)]

WN #5: 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 ensure that each resident of the home had their 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.

On June 5, 2017, at 0840 hours, Inspector #620 conducted a tour of the home's fourth, fifth, and sixth floor. During the tour Inspector #620 observed numerous personal items that had been used and unlabelled.

In the home's east spa room on a specific floor Inspector #620 observed 16 used nail clippers stored together in a pile on top of a storage container meant to store the nail clippers. Above the storage container the inspector observed a sign that stated, "nail clippers are no longer sterilized, please put residents nail clippers back in the residents labelled drawer (labelled by room number) when finished clipping nails. If a new pair of nail clippers are needed please let registered staff know they will be replaced with new ones!"

In the home's west spa room on the same floor Inspector #620 observed a used and unlabelled bottle of conditioner, two used unlabelled nail clippers on top of storage box meant to store the nail clippers.

In another of the home's west spa rooms Inspector #620 observed an unlabelled partially used shampoo container, an unlabelled partially consumed men's deodorant, and two visibly soiled unlabelled combs.

In another of the home's west spa rooms Inspector #620 observed a used and unlabelled bottle of shampoo, and a used and unlabelled bottle of no rinse skin cleanser.

Inspector #620 reviewed the home's policy titled, "Resident Care Equipment – RC-07-01-01" with a last review date of April 2017. The policy advised staff to, "Label all resident personal care items."

On June 16, 2017, Inspector #620 interviewed the ADOC regarding the unlabelled resident items that were identified by the Inspector during the initial tour of the home. The ADOC indicated that all residents' personal care items were to be labelled. They indicated that if the residents had their own hygiene products, they were to not to be left in the spa room. Staff were expected to bring the items back to the resident's room. [s. 37. (1) (a)]

WN #6: 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,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

Inspector #613 reviewed a CI report that was submitted to the Director on a specific date. The CI report described alleged staff to resident neglect. The CI report stated that resident #013 had reported to PSW #133, on a specific shift, that they had required specific continence care from the previous shift. The resident stated that they had informed a staff member on the previous shift of their care need; however, PSW #134 had told the resident that they had to wait until the next shift arrived on duty.

A review of the home's internal investigation notes identified that resident #013 had informed PSW #134 that they required specific continence care and PSW #134 had informed the resident that they have to wait for the next shift to assist them. In the investigation notes, PSW #134 identified that they had not reported to the next shift that resident #013 had requested the care.

A further review of the homes' investigation notes identified that PSW #133 stated that the resident had not received the continence care that they had requested.

Inspector #613 reviewed the resident #013's care plan in place at the time of the incident which revealed that the resident required a specific level of assistance with continence care from staff and that the resident was to receive the assistance at specific times and when needed.

The Inspector interviewed PSW #123, PSW #124 and PSW#126, who stated that they were expected to meet the care needs of all residents until the end of their shift. All stated that they were not allowed to tell a resident to wait for the oncoming staff to provide care. PSW #126 stated that they would provide the care to the resident and report to oncoming staff to take over the care, if it occurred at the end of their shift.

During an interview on June 9, 2017, with the DOC, they confirmed that it was not acceptable that PSW #134 had not provided continence care when requested by resident #013 and PSW #134 should not have told the resident to wait for the oncoming staff to provide the required care. The DOC stated PSW #134 had enough time to provide continence care to the resident and should have. [s. 51. (2) (b)]

2. Inspector #612 reviewed a CI report submitted by the home on a specific date which alleged neglect by PSW #103 towards resident #019. The CI report described that RPN #104 reported that on the specific date, they were made aware that resident #019 was found in a specific state, without having had continence care provided.

Inspector #612 reviewed resident #019's care plan in place at the time of the incident which stated that resident #019 was to receive specific continence care at specified times. The care plan also documented interventions specific to the level of assistance by a certain number of staff that the resident required.

Inspector #612 reviewed the investigation notes provided by the home. In the notes, PSW #103 confirmed that they had left the resident in their bed for a period of time, approximately three hours, and had not provided continence care to the resident. PSW #103 stated that the resident was displaying responsive behaviours and PSW #103 had not requested assistance from another staff member.

Inspector #612 interviewed PSW #105. They stated that they they discovered resident #019 lying in their bed with the appearance of not having received personal care. PSW #105 stated that they reported it to RPN #104, and that they and another PSW were able to provide personal care to resident #019.

Inspector #612 interviewed the DOC who stated that PSW #103 had received training from the Behaviour Supports Ontario (BSO) team to better support them when providing continence care for resident #019; however, PSW #103 had not implemented resident #019's individualized plan to manage the resident's continence needs. [s. 51. (2) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items were offered and available at each meal and snack.

During the course of the inspection, Inspector #612 was approached by resident #025 and resident #026 at separate times and they both stated that the home ran out of menu items during all meals.

On June 5, 2017, Inspector #612 observed the lunch dining service on a specific floor. The Inspector observed that the Dietary Aide (DA) #139 ran out of puree ravioli. The DA stated that they would call down to the kitchen for the two additional servings they required. A staff member ran to the other floors to see if there were any servings of puree ravioli. RPN #141 stated that they did not have enough puree ravioli for the two residents and that they would offer the residents the other option. RPN #141 stated that the two residents were more likely to eat the hot food option versus the cold food, which was what the second option was (sliced turkey on rye and tossed salad). RPN #141 stated that they ran out of food all the time. DA #139 confirmed that there were unable to get the two servings required for the residents.

On June 12, 2017, Inspector #612 observed the lunch service on a specific floor. DA #139 stated that they had run out of minced salad for the last two servings. They asked the two residents who had requested the minced salad if they would accept the other option, broccoli. The residents agreed. Another resident had requested a second helping of the minced salad and they were told that there was none left.

On June 15, 2017, Inspector #612 interviewed the Food Services Supervisor and Dietary Manager. They confirmed that they had run out of the options mentioned above during the June 5, and 12, 2017, meal services. The Dietary Manager stated that they had adjusted the menu so that during the next cycle, they would account for the additional servings required. [s. 71. (4)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows: 3. A response was made the complaint indicating, i. what the licensee had done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

Inspector #613 reviewed a CI report that was submitted to the Director on a specific date. The CI report described an allegation of staff to resident neglect. The CI report stated that on the specific date, resident #014 reported to PSW #130 that they did not have specific care provided to them through the night and that they did not have their call bell within reach. Resident #014 was unavailable for interviews or observation during the inspection.

A review of the home's internal investigation notes and progress notes failed to identify that a response was made to resident #014 indicating what the licensee had done to resolve their complaint.

A review of the home's policy titled, "Complaints and Customer Service" last revised April 2016, identified that the home would provide a written response to the complainant at the conclusion of the investigation.

During an interview on June 9, 2017 with the DOC, they were unable to provide written documentation that indicated that resident #014 had been informed of the outcome of the investigation. [s. 101. (1) 3. i.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to ensure that the security of the drug supply, including the following: 1. All areas where drugs were stored shall be kept locked at all times, when not in use.

On June 5, 2017, at 0927 hours, Inspector #620 observed two medication carts unlocked and unattended in a medication room, behind a nurse's station. The door of the medication room was unlocked and unattended. The Inspector observed the unsecured and unattended medications for nine minutes. RPN #120 returned to the medication room at 0936 hours. The Inspector observed RPN #120 lock the medication room; however, the two medication carts remained unlocked within the locked medication room.

Inspector #613 interviewed RPN #116 and RPN #120, who both verified that that registered staff were to ensure that the medication room was locked when out of a registered staffs view. Both RPN's stated that they would leave the medication room unlocked if registered staff were in the nursing station.

A review of the home's policy titled, "The Medication Storage" dated February 2017, identified that medication stored in a medication room must be locked at all times with the keys in the possession of the designated nurse.

During an interview on June 9, 2017, with the DOC, they confirmed that the medication room and medication carts were to be kept locked at all times, when registered staff were not inside the room. [s. 130. 1.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control (IPAC) program.

During the initial tour of the home on June 5, 2017, Inspector #612 observed two specific resident room's that both had isolation supplies hanging on the door way, however, there was no signage posted to indicate the type of isolation required in those rooms.

Inspector #612 reviewed Point Click Care and noted that a specific resident resided in one of the rooms. In their care plan it stated that the resident had Vancomycin-resistant Enterococci (VRE) and required contact precautions. In the other resident's care plan, who resided in the other room, it stated that the resident had Extended-spectrum beta-lactamases (ESBL) and required contact precautions.

On June 15, 2017, Inspector #612 observed that the two specific rooms still did not have signage posted indicating the type of isolation required in the room.

On June 15, 2017, Inspector #612 interviewed PSW #122 who stated that there should be a sign placed at the door of the resident's room, which indicated the type of isolation required.

On June 15, 2017, Inspector #612 interviewed RN #121 and RPN #131, and they stated that when isolation precautions were initiated for VRE or ESBL, they would place signage at the door of the resident's room indicating that contact precautions were to be utilized.

Inspector #612 reviewed the home's policy titled, "Vancomycin-Resistant Enterococcus (VRE)", last updated September 2016, which stated that when the laboratory confirms the resident has VRE staff were to implement contact precautions and apply room signage at the resident's doorway.

Inspector #612 reviewed the home's policy titled, "Extended Spectrum Beta Lactamase (ESBL)", last updated September 2016, which stated to implement contact precautions for any resident with ESBL.

Inspector #612 reviewed the home's policy titled, "Contact Precautions", last updated September 2016, which stated that contact precautions were additional precautions used to prevent the spread of infection. It also stated that staff were to place contact precaution signage at the resident's room doorway to advise visitors to speak with a nurse before entering the room.

On June 16, 2017, Inspector #612 interviewed the ADOC #102 who confirmed that staff

were to apply the appropriate signage on the doorway of a resident room who was on contact precautions. [s. 229. (4)]

Issued on this 14th day of July, 2017

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

Original report signed by the inspector.