Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON L1K 0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON L1K 0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 18, 2014	2014_288549_0040	O-001084-14	Resident Quality Inspection

Licensee/Titulaire de permis

HALIBURTON HIGHLANDS HEALTH SERVICES CORPORATION
7199 Gelert Road Box 115 HALIBURTON ON K0M 1S0

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

HIGHLAND WOOD
7199 Gelert Road P.O. Box 115 HALIBURTON ON K0M 1S0

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

RENA BOWEN (549), MATTHEW STICCA (553)

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): November 3, 4, 5, 6,7, 10,11,12,13, 2014.

The following Log # O-001261-14, was inspected as part of the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with several family members, several Residents, the President of the Family Council, the President of the Resident's Council, several Housekeeping Aides, several Personal Support Workers(PSW), several Registered Practical Nurses (RPN), several Registered Nurses (RN), Activity Aides, the Life Enrichment Coordinator, the Assistant Director of Care(ADOC), the Director of Care(DOC), the Physio Therapist, the Dietary Lead, the Food Services Manager(FSM), the Registered Dietitian(RD)and a Physician.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Skin and Wound Care
Sufficient Staffing

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

11 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

O. Reg. 79/10 s.48 (1) (2) requires a long-term care home to ensure that there is a skin and wound care program.

O. Reg. 79/10 s.30 (1) (1) requires a long-term care home to have a written description of the program that includes relevant policies, procedures and protocols.

On November 7, 2014 the Director of Care confirmed with Inspector #549 that the Skin and Wound Management Protocol is the home's Skin and Wound Care Program.

The home's Skin and Wound Management Protocol, policy # VII-G-20.10 current revision dated February 2014 states under the section titled Background states: the RAI MDS assessment tool will produce a Pressure Ulcer Risk Score(PURS), ranging from 0 (lowest risk) to 8 (highest risk) for each resident.
Under the section title Procedure subsection #2 the policy states: with resident exhibiting altered skin integrity, including skin breakdown, pressure ulcer, skin tears or wounds
a. Conduct a skin assessment
b. Provide immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection as required
c. Refer the resident to the Registered Dietitian.

Under subsection #3 the policy states: Reassess according to resident's PURS score:
a. 6-8 = weekly
b. 3-5= minimum of monthly
c. 0-2= q3months or if there is a change in the resident's condition.

The assessment tool to be completed is attached to the policy and number VII-G-20.10(b) titled Skin & Wound- Weekly Skin Surveillance Tool and Worksheet.

1.Resident #1's MDS assessment indicated a Stage 2 pressure ulcer and a Stage 2 stasis ulcer.

Resident # 1's health care file documentation was reviewed over a period of three months related to Skin and Wound care. It was noted during this time period that the RAI MDS Pressure Ulcer Score has not been completed for Resident #1.

The Skin Assessment document on Resident #1's health care file which is being completed by the registered staff quarterly is not the Skin & Wound- Weekly Skin Surveillance Tool Worksheet VII-G-20.10(b) as per the Skin and Wound Care Management Protocol.

On November 7, 2014 RN S#103 indicated to Inspector #549 that the registered staff do not use the RAI MDS Pressure Ulcer Risk Score or the Skin & Wound- Weekly Skin Assessment Surveillance Tool and Worksheet as stated in the Skin and Wound Care Management Protocol policy # VII-G-20.10 dated February 2014.

2. Resident #4 was admitted with a Stage 2 pressure ulcer documented on the admission notes and admission MDS assessment.

The residents health care file was reviewed for a period of three months related to Skin and Wound care. It was noted during this time period that the RAI MDS Pressure Ulcer Score has not been completed for Resident #4

The Skin Assessment document on Resident #4's health care file which is being completed by the registered staff quarterly is not the Skin & Wound- Weekly Skin Surveillance Tool Worksheet VII-G-20.10(b) as per the Skin and Wound Care Management Protocol.

On November 10, 2014 the Director of Care confirmed that the registered staff do not comply with the home's Skin and Wound Care Management Protocol policy # VII-G-20.10 and that the Skin Assessment document which is completed by the registered staff quarterly is not part of the Skin and Wound Care Management Protocol. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Skin and Wound Management Protocol policy # VII-G-20.10 is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. Licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, be reassessed at least weekly by a member of the registered nursing staff , if clinically indicated.

Resident #1's MDS assessment indicated that the resident has a Stage 2 pressure ulcer and a Stage 2 stasis ulcer.

Resident #1 continues to exhibit altered skin integrity.

Upon review of Resident #1's health care file it was noted that a reassessment of the resident's skin condition by a member of the registered staff was completed quarterly.

2.Resident #4 was admitted with a Stage 2 pressure ulcer as per the health care file admission note and the admission MDS assessment.

Resident #4 continues to exhibit altered skin integrity.

Upon review of Resident #4's health care file it was noted that a reassessment of the resident's skin condition by a member of the registered staff was completed quarterly.

During a discussion on November 7, 2014 with the RN S#103 it was indicated to Inspector #549 that the PSW's assess all resident's skin condition weekly while giving the resident a bath and that quarterly skin reassessments are completed by registered staff using the form titled Skin Assessment.

RN S#103 also indicated that registered staff do not complete skin assessments weekly for resident's exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds.

The Director of Care confirmed to Inspector #549 that the registered staff do not reassess resident's exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, at least weekly when clinically indicated.

The Director of Care indicated to Inspector #549 that the home has recently put together a Skin and Wound Care committee which is a joint effort with staff from Haliburton Hospital to assist with skin and wound care in the home. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcer, skin tears or wounds, be reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Family Council advice was requested in the developing and carrying out of the satisfaction survey.

The home's Satisfaction Survey for 2014 has not been distributed yet. The Director of Care indicted to Inspector #549 that the Satisfaction Survey will be distributed before the end of 2014.

The home's 2013 Satisfaction Survey was distributed September 23, 2013.

On November 3, 2014 the Director of Care completed the LTCH Licensee Confirmation Checklist- Quality Improvement & Required Programs. In response to question #9: Does the licensee seek the advice of the Family Council in developing and carrying out the survey, and acting on its result the Director of Care marked no on the document.

On November 11, 2014 in a discussion with the President of the Family Council it was indicated to Inspector #549 that the current President does not recall the home seeking advice from the Family Council in the developing and carrying out of the satisfactions

survey for 2013.

Inspector #549 reviewed the Family Council meeting minutes for January 2013 to October 2014 there are no minutes reflecting that the home requested advice from Family Council in developing and carrying out the satisfaction survey for 2013.

On November 12, 2014 the Assistant Director of Care confirmed with Inspector #549 that the home did not seek the advice of the Family Council in developing and carrying out the home's Satisfaction Survey for 2013. [s. 85. (3)]

2. The licensee has failed to ensure that the advice of Residents' Council was sought in developing and carrying out the satisfaction survey and in acting on its results.

Inspector #553 reviewed Residents' Council minutes for October 2013- October 2014, there is no indication in the minutes that the home sought the advice of the Residents' Council in developing and carrying out the satisfaction survey.

Inspector #553 interviewed the Residents' Council President who indicated to Inspector #553 that she is unaware of any involvement with the satisfaction survey.

The Life Enrichment Coordinator is the Residents' Council liaison for the home.

The Life Enrichment Coordinator indicated to Inspector #553 that Residents' Council does not have any involvement in the development of the satisfaction survey. [s. 85. (3)]

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 licensee seeks the advice of the Family Council and the Resident's Council in developing and the carrying out of the satisfaction survey, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a drug is to be destroyed is a controlled substance (Fentanyl Patches), that it is done in accordance with legislative requirements.

When RN S#103 was interviewed by Inspector #553 regarding destroying of controlled substances, RN S#103 indicated that for controlled substances there are two staff members that sign off on the Narcotic/Controlled Substance disposal record sheet. From there the controlled substances are placed in a stationary locked safe located within the medication storage room. The pharmacist and the ADOC together will dispose and denature the controlled substances when the pharmacist comes into the home to do so. When asked specifically about Fentanyl Patches, RN S#103 indicated that currently the Fentanyl Patches are being removed and then thrown into the "regular garbage". This "regular garbage" is then placed into a larger garbage bin that is collected by maintenance and removed from the building. RN S#103 stated that they are not aware of any practice within the home that has the Fentanyl Patches being accounted for once they are removed from a Resident.

In doing this practice, the Licensee has failed to ensure that a controlled substance is being destroyed in accordance with legislative requirements. [s. 136. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a controlled substance specifically Fentanyl Patches are destroyed in accordance with legislative requriements, to be implemented voluntarily.

WN #5: 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 that a written response was received by Residents' Council related to concerns or recommendations within 10 days.

Inspector #553 reviewed of Residents' Council minutes from October 2013 to October 2014. It was noted in the minutes for this time period that there were concerns about food quality in the home.

The Life Enrichment Coordinator is the liaison for the licensee on the Residents' Council. When asked to review written responses regarding the food concerns raised by the Residents' Council between October 2013 and October 2014, the Life Enrichment Coordinator indicated to Inspector #553 that the concerns have been addressed in the "Diner's Club" meeting.

In an interview the Food Service Manager indicated to Inspector #553 that the home has never written a formal response to a food concern to the Residents' Council. The Food Service Manager also stated that the home will address the concerns verbally at the "Diner's Club" meeting, and the minutes of the "Diner's Club" meetings are then read at the next Residents' Council meeting. The membership of the "Diner's Club" is not the same as the membership on Residents' Council. [s. 57. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident's heights are measured annually.

It was confirmed by Inspector #549 that resident weights and heights are documented in the resident's electronic health care file.

Thirty resident health care files were reviewed during Stage 1 of the Resident Quality Inspection and were found to be lacking an annual recorded height measurement.

Inspector #549 spoke with charge RN S#115 on November 4, 2014 who confirmed that the resident heights are obtained on admission; however, the home does not measure heights annually thereafter. [s. 68. (2) (e) (ii)]

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. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the menu cycle was reviewed by the Residents' Council.

Inspector #553 interviewed the Food Service Manager on November 13, 2014 and it was disclosed that the Fall and Winter Menus were not reviewed with Residents' Council. The Fall and Winter Menus were only reviewed with the "Diner's Club" during a meeting held on October 16, 2014.

The members of the "Diner's Club" are not the same members as the Residents' Council [s. 71. (1) (f)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements.

During the initial tour Inspector #553 noted that not all required information was posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements.

The LTCH Licensee Confirmation Checklist-Admission Process was completed by the Director of Care on November 3, 2014.

The following sections on the LTCH Licensee Confirmation Checklist-Admission Process related to posting of required information were marked with a "no" as not being posted:

1.The home's policy to promote zero tolerance of abuse and neglect of residents. [s.79. (3)(c)]

2.The home's policy to minimize the restraining of residents. [s. 79.(3)(g)]

3.A copy of the service accountability agreement as defined in section 21 of the Commitment to the Future of Medicare Act, 2004 entered between the licensee and a local health integration network. [s.79.(3)(g.1)

4.An explanation of whistle-blowing protection related to retaliation. [s.79.(3)(p)]

The Director of Care confirmed during a discussion with Inspector #549 that the above required information was not posted in a conspicuous and easily accessible location in a manner that complies with the requirements. [s. 79. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed in as much detail as possible in the circumstance of an unexpected or sudden death. [O-001261-14]

A Critical Incident Report was completed by the Director of Care 5 days after a sudden or unexpected death.

The Director of Care confirmed during a discussion with Inspector #549 on November 10, 2014 that the Director was not informed immediately of the unexpected or sudden death. [s. 107. (1)]

WN #10: 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 stored in an area of a medication cart were secured and locked.

Observation made by Inspector #553 on November 5, 2014 at 15:10hrs:

It was observed by Inspectors #549 and #553 at 15:10hrs on November 5, 2014 that the medication storage room door was propped open by the medication cart. This left the medication storage room unlocked and unattended. At the same time the medication cart was also left unlocked and Inspectors #553 and #549 were able to enter into the medication room and access the drawers of the medication cart with ease. There were three staff members located in the office adjacent to the medication room with the door shut, with the medication cart and room not within sight. No indication of the staff members being aware of the medication room being unattended and the door being wide open. Inspector #553 went and retrieved a Registered Staff member while Inspector #549 stayed in the unattended medication room. RPN S#102 indicated to Inspector #553 that the expectation for an unattended medication cart is that the medication cart is to be locked and that the medication storage room is to be locked when not in use. RPN S#102 identified to Inspector #553 and #549 that they had failed to meet these expectations.

Observation made by Inspector #553 on November 6, 2014 at 09:25hrs:

It was observed that the medication cart was left unattended and unlocked outside of the dining room on November 6, 2014 at 09:25hrs. RN S#101, who was dispensing medications to a Resident, was approximately 20 feet away and around the corner leaving the medication cart out of RN S#101's vision. As Residents were leaving the dining room after breakfast, they were passing by the unlocked and unattended medication cart. Inspector #553 was able to easily access the drawers on the medication. Inspector #553 remained with the medication cart until RN S#101 came back to the medication cart at 09:29hrs, when asked what the expectation was with an unattended medication cart, RN S#101 indicated that the medication cart should have been locked. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area.

While observing in the medication room on November 11, 2014 at 14:54hrs, Inspector #553 opened the refrigerator located in the medication storage room. The refrigerator did not have a lock in place. The refrigerator had a supply of injectable Ativan, which is considered to be a controlled substance. On November 12, 2014 the same issue was identified. This was brought to the attention of the DOC who remedied the issue with the placement of a lock on the refrigerator to ensure that controlled substances are double-locked. [s. 129. (1) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information

Specifically failed to comply with the following:

s. 225. (1) For the purposes of clause 79 (3) (q) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 79 of the Act includes the following:
1. The fundamental principle set out in section 1 of the Act. O. Reg. 79/10, s. 225 (1).
2. The home's licence or approval, including any conditions or amendments, other than conditions that are imposed under the regulations or the conditions under subsection 101 (3) of the Act. O. Reg. 79/10, s. 225 (1).
3. The most recent audited report provided for in clause 243 (1) (a). O. Reg. 79/10, s. 225 (1).
4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service. O. Reg. 79/10, s. 225 (1).
5. Together with the explanation required under clause 79 (3) (d) of the Act, the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act. O. Reg. 79/10, s. 225 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the most recent audited report is posted.

On November 3, 2014 during the initial tour Inspector #553 noted that the most recent audit report was not posted in a conspicuous and easily accessible location in the home.

The LTCH Licensee Confirmation Checklist- Admission Process was completed by the Director of Care on November 3, 2014. Under Section 3 Subsection d of the checklist "the most recent audited reconciliation report is posted", was marked with a No.

On November 4, 2014 during a discussion with Inspector #549 the Director of Care confirmed that the most recent audited report was not posted. [s. 225. (1) 3.]

Issued on this 18th day of November, 2014

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

Original report signed by the inspector.