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**

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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 |
|---|---|---|---|
| Feb 17, 2017 | 2016_357648_0013 | 034158-16 | Resident Quality Inspection |

## Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

KENNEDY LODGE
1400 KENNEDY ROAD SCARBOROUGH ON M1P 4V6

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

JOVAIRIA AWAN (648), JANET GROUX (606)

## 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): December 14, 16, 19, 20, 21, 22, and 23, 2016**

**During the course of the inspection, the inspectors conducted observations of residents and home areas, medication administration, infection control prevention and practices, reviewed clinical health records, staffing schedules/assignments, minutes of Residents' Council, a Family Council questionnaire, minutes of relevant committee meetings, and relevant policies and procedures.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Environmental Services Manager (ESM), Programs Manager, Housekeeping staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Substitute Decision Maker (SDM), and Residents.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Falls Prevention**
**Infection Prevention and Control**
**Medication**
**Nutrition and Hydration**
**Residents' Council**
**Safe and Secure Home**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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.

The inspector observed on December 14, 2016, at 1000 (hours) hrs on the second floor, out of view from the nursing station, resident #001, sliding off the wheelchair. The inspector immediately went over to resident #001 to prevent him/her from sliding down any further and called out to staff for immediate assistance. RN #102 came out of the nursing station and called out for other staff to assist. PSW #133 and #134 and housekeeping staff #126 came over immediately to assist. Resident #001 was observed at this time to slide down onto the footrests. RN #012, PSW #133 and #134 lifted the resident back into the chair and was repositioned with the wheelchair titled back.

Review of resident #001's plan of care, indicated resident was high risk for falls related to multiple medical diagnoses. The plan of care directed staff to have a bed and wheelchair alarm and to tilt the wheelchair.

Interview with PSW #106 revealed prior to him/her going on break, he/she had tilted the wheelchair to ensure the resident did not slide down off his/her chair and revealed he/she did not put the chair alarm on the chair that morning because the clip that attached the alarm to the resident was missing and needed to be replaced. He/she stated that the alarm had been sitting at the nursing station at least for a few days waiting to be fixed.

Interview with RN #102 revealed resident #001 is at high risk for falling and staff were directed to monitor him/her. The RN stated the plan of care directs staff to ensure resident #001 to have a bed/chair alarm on at all times as and for his/her wheelchair to be titled when he/she is sitting in it and this was not followed. He/she stated that the chair alarm will be place on the chair immediately.

The DOC stated the staff failed to follow resident #001’s plan of care. [s. 6. (7)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance - to ensure the care set out in the plan of care is provided as specified in the plan,***
***- to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home was maintained in a good state of repair.

During stage one and stage two of the RQI inspection, the following observations were made in the home:

Resident Room:
- On December 14, 2016, exposed wall in apparent disrepair was observed in the shared resident bathroom revealing a rectangular patch of damaged and cracking wall surface. The outside surface of the bathroom door also presented with a circular dent measuring an estimated two and a half inches.
- On December 20, 2016, the was observed again and remained in the same state of

disrepair for both of the above observations.

Resident Room:
- On December 15, 2016, in the shared resident bathroom, chipped and peeling paint under sink were observed.
- On December 20, 2016, the was observed again and remained in the same state of disrepair.

Resident Room:
- On December 14, 2016 a portion of wall between the bathroom and room door was observed with a large open hole exposing concrete through paint and drywall. The hole appeared to be approximately eight inches in length, and two inches in height at the widest part as measured by the inspector.
- On December 20, 2016, the was observed again and remained in the same state of disrepair.

Resident room:
- On December 14, 2016, a large damaged hole at the baseboard corner outside of the shared resident bathroom was observed. The hole exposed the wall with crumbling materials and a large patch of unpainted patched wall extended from this area of disrepair approximately 1.5 X 3 feet as measured by the inspector. In the shared resident bathroom, the base of wall behind toilet (to the right side when facing wall) was observed with visibly cracked and crumbling surface and a large tile was displaced which exposed the wall behind the toilet.
- On December 20, 2016, the was observed again and remained in the same state of disrepair.

Resident Room:
- On December 14, 2016, the bottom of the wall column next to the closet was observed with chipped drywall and concrete exposing the base structure of wall. The door of the shared resident bathroom was observed in disrepair with the surface prying away from the door structure upon attempt to open it, with the surface of the door visibly separating on lower half portion of the door. On the wall facing the resident beds, four holes behind resident room door and a circular cracked dent in wall where door knob makes contact with wall were noted.
- The room was observed again on December 20, 2016, and remained in the same state of disrepair. However the surface board of the bathroom door appeared to have been glued to door and did not separate when inspector opened and closed door.

Resident Room:
- On December 14, 2016, the baseboard by the bathroom was observed in disrepair. The wall facing bed A appeared with chipped and cracked paint. A large patch of unpainted and rough drywall under sanitizer dispenser by the main room door was also observed.
- On December 20, 2016, the drywall appeared to have been painted over. The other initial observations remained the same. Additionally, a hole approximately nine by one and a half inches as measured by the inspector was observed the bottom of the baseboard, exposing the wall opposite the resident beds.

Record review of the maintenance care logs from MaintenanceCare.com titled Status Task List for the period of June 1, 2016, to December 16, 2016, did not demonstrate requisitions related to the observed disrepair for the identified rooms had been submitted to the maintenance department.

Record review of the document titled Resident Room Maintenance Audit dated November 5, 2016, for the rooms on the second and third floors did not capture the disrepair related to the damaged walls and holes in the residents rooms identified above.

Record review of home's policy entitled Quarterly Routines – Painting (revised January 21, 2015) in the homes Environmental Services Manual identified the purpose of the policy was to ensure the appearance of the home is aesthetically pleasing. The policy included the ESM or designate was required to inspect the home on a quarterly basis. Procedures in the policy included the inspection fall resident rooms, with a table identifying the areas for paint or repair, the correction action, the start date, and the completion date.

Review of the home's policy entitled Preventative Maintenance Systems and Schedule (revised January 21, 2015) in the homes Environmental Services Manual identified the purpose of the policy was to ensure the resident's and staff environment was well maintained. The procedures outlined that the preventative maintenance will be carried out on a daily, weekly, and monthly basis.

Interview with PSW #121 identified that maintenance concerns related to disrepair were to be reported to the maintenance department. PSW #121 revealed he/she was aware of the damage to a specified room and it had not been reported through the maintenance communication system or to the supervising nurse. Interview with PSW #114 identified

that staff were able to report maintenance issues including disrepair in the residents' rooms through the homes on line maintenance care program on their point of care screens. PSW #114 revealed he/she had provided routine care to residents in the identified rooms. PSW #114 denied prior knowledge of the disrepair when identified by the inspector but also stated that it should have been reported to the charge nurse or to the maintenance department using the on line maintenance system. PSW #114 acknowledged the disrepair had not been reported.

The housekeeping staff #113 told the inspector that he/she had verbally reported the disrepair identified in the identified rooms to the maintenance department in the past. Staff #113 acknowledged the apparent disrepair in the identified rooms was not an acceptable environment for residents to live in.

Interview with registered nurse (RN) #115 identified that he/she and other staff in the home were able to report maintenance issues including disrepair in resident rooms through the homes on line maintenance care program on their point of care screens and any other computer in the home. RN #115 stated that staff were able to communicate maintenance concerns to him/her which would then be put into the homes on line maintenance program. RN #115 acknowledged the disrepair in rooms the identified rooms and confirmed staff would be expected to report these areas of disrepair but that it was not done.

Interview with the ESM identified the maintenance department was to conduct routine visual inspections and quarterly audits in order to identify rooms with disrepair. ESM was unable to demonstrate visual inspections or quarterly audits had been conducted to identify the disrepair in the identified rooms.

Interview with the homes ED revealed all staff were expected to communicate disrepair in the home (including resident rooms) to the maintenance department through the home's on line maintenance system. The ED acknowledged staff did not report the areas of disrepair for the rooms identified during the inspection, and that the home's policy for communicating issues to maintenance department was not followed. The ED revealed the home was aware of the holes in the resident room walls confirming they had been present prior to June 2016 and not been addressed. [s. 15. (2) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home is maintained in a good state of repair, to be implemented voluntarily.***

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**WN #3: 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 can be easily accessed and used by residents.

Each resident bathroom contains a call system. The call system has three parts: the call plate that is attached to the wall, this plate contains the cancel button when call is answered, a clear plastic pull string with a green male plug and then a green pull string with a female adaptor. The male and female adaptor joins together and or pulls apart. On December 14, 2016, at 1025hrs, the inspector tested the call bell system in specified

resident rooms.

The inspector observed the two call bell strings would separate from the green adaptor when pulled and the call system would not activate. PSWs #130 and #131 also tested the call bell system concluded the same observation as the inspector's. Resident #012 who resides in one of the identified rooms when asked if the call bell ever separates and does not ring
for him/her replied that it had been like that for a while now.

Interview with PSW #130 and #131revealed that the call bell strings when pulled should not pull apart when pulled and stated they would let the charge nurse know so maintenance could fix it right away. [s. 17. (1) (a)]

2. Observations conducted during stage one identified each resident bathroom had a call bell system. The call system had three parts which included the call plate attached to the wall. The call plate possessed a cancel button which could be pressed when the call bell was answered. At the call plate, a short green chord with a green male plug connected the clear plastic pull chord with a female plug adaptor. The male and female adaptor joined together and could be pulled apart forcefully if needed.

The inspector tested the pull cord for the call bell in resident #003's bathroom during stage one on December 15, 2016, at 1357 hrs which revealed the bathroom call bell would separate at the junction of the green chord and the clear chord when pulled gently, and the call system would not activate.

During a staff interview, PSW #121 tested the call bell on December 20, 2016, with the inspector and concluded the call bell did not activate when pulled. PSW #121 acknowledged resident #003 would not have been able to contact staff had they attempted to use the call bell and that it put resident #003 at risk. PSW #121 reported that the non-functional call bell would be reported to the maintenance staff for repair.

During the staff interview, PSW #114 tested the call bell in resident #003's bathroom on December 21, 2016, at 1020 hrs with the inspector and concluded again that the call bell did not activate when pulled due to being dislodged from the connecting chord at the call plate. This demonstrated the call bell was not reported to maintenance on December 20, 2016. PSW #114 acknowledged resident #003 would not be able to notify staff if pulling the call bell, and that it put resident #003 at risk.

A subsequent observation made by inspector at 1050 hrs on December 21, 2016, for resident #003's call bell revealed the call bell had been fixed so that it activated when pulled from the clear chord.

Interview with RN #115 acknowledged the lack of activation of the call posed a risk to resident #003 and confirmed staff had reported the call bell issue to him/her and that it was immediately reported to maintenance.

Interview with ESM revealed the staff are expected to check the ball bells daily and report to maintenance when an issue was identified. The maintenance department would be expected to address the issue immediately. [s. 17. (1) (a)]

***Additional Required Actions:***

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

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services**

**Specifically failed to comply with the following:**

**s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,**
**(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).**

**s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,**
**(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that all equipment, devices, assistive aids and positioning aids in the home was kept in good repair.

The inspector observed on December 14, 2016, at 1000 hrs on the second floor, out of view from the nursing station, resident #001, sliding off the wheelchair. The inspector immediately went over to resident #001 to prevent him/her from sliding down any further and called out to staff for immediate assistance. RN #102 came out of the nursing station and called out for other staff to assist. PSW #133 and #134 and housekeeping staff #126 came over immediately to assist. Resident #001 was observed at this time to slide down onto the footrests. RN #012, PSW #133 and #134 lifted the resident back into the chair and was repositioned with the wheelchair titled back.

Review of resident #001's plan of care date December 1, 2016, indicated resident is high risk for falls related to multiple compounding medical diagnoses. The plan of care directed staff to have a bed and wheelchair alarm and to tilt the wheelchair.

Interview with PSW #106 revealed resident #001 did not have a chair alarm the morning of December 14, 2016, because the bed/chair alarm was missing the clip that attached the alarm to a chair and it was at the nursing station for the last few days waiting to be fixed. The PSW he/she was unaware if the nurse was aware that the bed/chair required to be fixed.

Interview with RN #102 revealed he/she was not aware that resident #001's bed/chair alarm required to be fixed. The nurse stated staff are to inform the charge nurse when the chair alarm is not working so they can immediately follow up on and he/she confirmed this was not done. The RN stated the chair alarm belonging to resident #001 was located in the nursing station and was not functioning so a new chair alarm was placed on the resident after the inspector brought it his/her attention.

Interview with the DOC confirmed the home's practice is for the PSW to immediately inform the charge nurse verbally when a chair alarm is not working so it can be fixed or replaced immediately.

The licensee failed to ensure that resident #001’s bed/chair alarm was kept in good repair. [s. 90. (2) (b)]

2. The licensee failed to ensure that procedures developed to ensure that the heating systems were in a good state of repair and inspected at least every six months by a certified individual and that documentation was kept of the inspection.

During stage one information gathering, it was reported through family interview that resident #005 and other residents found the recreation room and library cold.

An observation conducted on December 22, 2016, with the environmental services manager (ESM) identified the temperature on the first floor resident library and lounge was between 17.5 and 18.5 degrees Celsius. The ESM used an electronic laser thermometer during this observation with the inspector to determine the temperature. The ESM confirmed the rooms' ambient temperature was not at 22 degrees as per the legislative requirement. The ESM identified that the incremental heating unit towards the north wall of the room was not functional.

Review of the homes policy of the home's policy entitled HVAC systems Incremental Units, revised January 21, 2015, identified the ESM or designate is required to inspect the incremental heating units on a monthly basis. Review of the policy entitled Semi-Annual Routines Central Heating Air Conditioning Units further identified the ESM or designate was required to inspect the central heating air conditioning units on a semi-annual basis. The procedure of this policy included to ensure the heating systems were cleaned and in good state of repair and inspected at least every six months by a certified individual and that documentation is kept of the inspection.

Interview with ESM revealed the home was made aware of the faulty incremental heating unit at the onset of the winter season. Upon further inquiry, the ESM was unable to demonstrate identification (through monthly or bi-annual inspections) of the non-functional incremental heating unit on the first floor prior to the onset of the winter through the implementation of the homes policies. The ESM revealed routine temperature checks were only completed for the third floor and not completed for the remainder of the home.

Interview with the ED identified the homes expectation was to maintain daily temperature logs for each floor in the home. The ED confirmed this had not been done and acknowledged the homes policy for monthly or annual inspection of the incremental units had not been completed in order to identify the faulty incremental heating unit prior to the winter season. [s. 90. (2) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all equipment, devices, assistive aids, and positioning aids in the home are kept in good repair including but not limited to resident wheelchairs., to be implemented voluntarily.***

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**WN #5: 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 the storage of drugs was secured and locked.

The inspector observed on December 15, 2016, at 1121 hrs, as he/she was walking by the main floor north unit, the medication room located at the back of the nursing station, an unlocked medication cart containing medications for the residents on the main floor north nursing station, inside the medication room with the door open and unlocked and accessible to anyone nearby. It was further observed by the inspector three unidentified residents near the nursing station when this was observed.

Interview with RPN #103 revealed he/she had just left to complete a treatment for a resident and had forgotten to lock the medication cart and close the medication room door and confirmed he/she should have locked the medication cart and close the door to the medication room before leaving the area.

Interview with the DOC confirmed it was unacceptable for the medication cart and room to be left unlocked.

The licensee failed to ensure the storage of drugs were secured and locked. [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 controlled substances are stored in a locked area., to be implemented voluntarily.***

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**WN #6: 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 failed to ensure that steps are taken to ensure the security of the drug supply, access to these areas shall be restricted to I persons who may dispense, prescribe or administer drugs in the home, and ii the Administrator.

The inspector observed on December 15, 2016, at 1121 hrs, the medication room located in the main floor north wing, wide open with PSW #104 standing inside the room by him/herself. The PSW stated that he/she was in there only for a few minutes getting something and RPN #103 had just left to do something because it was doctor's day and he/she would be returning soon. When the inspector asked the PSW if the home permits PSWs to have access to the medication room, PSW#104 responded that sometimes the PSW are allowed to go in the medication room to get resident care supplies which were located in the cupboards in the medication room.

Interview with PSW #105 and PSW #101 revealed when they need resident care supplies, the registered staff are responsible to get them from the medication room and confirmed PSWs are not allowed to enter the medication room.

Interview with RPN #103 confirmed PSWs are not permitted in the medication room.

Interview with the DOC confirmed only registered staff should have access to the medication room and stated PSW #104 should not have been permitted in the medication room. [s. 130. 2.]

***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 drugs are stored in an area or a medication cart is secure and locked,, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.**

**Findings/Faits saillants :**

1. During stage one information gathering, it was reported through family interview that resident #005 and other residents found the recreation room and library were cold.

Observation conducted on December 22, 2016, with the ESM identified the temperature on the first floor resident library and lounge was between 17.5 and 18.5 degrees Celsius. During this observation, it was confirmed that the rooms' ambient temperature was not at 22 degrees as per the legislative requirement.

Interview with ESM revealed the home only monitored daily temperature on the third floor and was unable to demonstrate how the home maintenance a minimum 22 degrees Celsius temperature in all resident areas.

Interview with the executive director identified the homes expectation was to maintain daily temperature logs for each floor in the home. ED confirmed that this had not been done.

The ED and ESM did not demonstrate the home was maintained at a minimum of 22 degrees Celsius. [s. 21.]

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**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 :**

1. The licensee has failed to ensure that each resident who is incontinent received 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.

During the stage one of the RQI resident #002 triggered for incontinence based on the most recent MDS assessment.

Review of resident #002's progress notes indicated the resident was transferred to identified date and returned to the home 16 days later, with a medical diagnosis. Resident #002 was again transferred to the hospital on a following identified date and, returned some days later with a medical diagnosis. Further review indicated the resident was noted to be weaker, and tired easily when walking and now required one person assistance for all activities of daily living (ADLs).

Review of the home's policy entitled, "Continence Care", LTC-E-50, revised date May 2013, indicated the nurse will initiate the three day continence assessment on admission and/or if there is a change in level of continence.

Review of an email dated on an identified date sent by the home indicated a resident who previously was continent on admission or in the previous quarter and is now incontinent, that would be a significant change and the continence assessment tool would be used. The email further indicated the home had used a continence assessment entitled, “Admission/Quarterly Continence Assessment (ON)” prior to October 2016 and was replaced with the assessment entitled, “Continence Assessment 2016”.

Interview with RPN #122, #110, RN #112, #115, revealed all residents receive a continence assessment on admission and when there is a change in the resident's status. The above mentioned staff confirmed the resident’s PCC assessments did not indicate that a continence assessment was completed when he/she returned from the hospital with a change in condition.

Interview with the DOC confirmed the home’s practice to complete a continence assessment when a resident has had a change in his/her condition. The DOC did not demonstrate that a continence assessment was completed for resident #002. [s. 51. (2) (a)]

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**WN #9: 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 the nutrition and hydration programs include height upon admission and annually thereafter.

During the stage one assessment census record reviews of the most recent height revealed the following residents heights had not been obtained annually.

Residents heights were last obtained for resident #009, resident #010, resident #011, and resident #012 on identified dates in 2015.

Interview with RN #115 and the DOC revealed residents heights are expected to be obtained on admission and annually after. [s. 68. (2) (e)]

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**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 participate in the implementation of the program.

Review of the home's policy entitled, Cleaning/Disinfecting/Sterilizing Resident Equipment, index IPC-C-10, effective date May 2014, directs staff to clean/disinfect equipment/items in direct contact with a resident before use in the care of another resident.

During the initial tour on December 14, 2016, on the main, second and third floor south and north wing units, the inspector observed all sit stands and hoyer lifts had a container of Accell sanitizer attached to each of them.

The inspector observed on December 22, 2016, at 0940n hrs and at 1110 hrs on the third floor, north wing, a sit stand lift parked in the hallway did not have an Accell sanitizer confirmed by PSW #125 and PSW #135 that it should have one but did not they said they will go to the nursing station and get one to put on the lift. At 1058 hrs, on the main floor, north wing unit a hoyer lift parked in the hallway close to the stairwell exit did not have an Accell sanitizer. The above PSWs revealed the hoyer and sit stand lifts are to be cleaned and disinfected using the Accell wipes located on the lift after each resident use. The above mentioned staff stated the lifts should always have the sanitizer on it and if it was missing they must inform the charge nurse who will get a replacement immediately.

Interview with the DOC revealed during morning rounds, it was the responsibility for all managers to monitor and ensure that all transfer equipments such as hoyer and sit stand lifts should always have a container of Accell sanitizer attached to the lift so it is accessible to staff to clean and disinfect the lift before it is used for another resident.

The DOC informed the sit stand and hoyer lifts identified by the inspector were replenished with the Accell sanitizers after the inspector brought it to the attention of the home. [s. 229. (4)]

**Issued on this 22nd day of February, 2017**

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

**Original report signed by the inspector.**