1. The licensee failed to ensure that the written procedures related to how the licensee deals with complaints complies with the regulations.

The policy/procedure, related to complaints, provided by the home on January 15, 2014 and dated January 14, 2014 does not clearly identify that all written and verbal complaints made to the licensee or a staff member concerning the care of a resident or operation of the home are to be dealt with using the identified procedure.

The home's policy/procedure does not include that complaints will be investigated and that a response will be provided to the complainant within ten business days of the receipt of the complaint, or that if the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

The home's policy/procedure does not include actions to be taken if the complaint cannot be investigated and resolved within ten business days. [s. 21.]

***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 ensuring there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints, to be implemented voluntarily.***

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**WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act**

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

**s. 23. (1) Every licensee of a long-term care home shall ensure that,**
**(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:**
**(i) abuse of a resident by anyone,**
**(ii) neglect of a resident by the licensee or staff, or**
**(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).**
**(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).**
**(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).**

**Findings/Faits saillants :**

1. The licensee of the long term care home did not ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that was reported to the licensee was immediately investigated.

In January 2014, resident #403 reported to nursing staff that items went missing from their bedside table. Registered staff left a note for the Administrator and Director of Care however, the Administrator confirmed there was no formal investigation immediately initiated. [s. 23. (1) (a) (i)]

***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 ensuring that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that was reported to the licensee was immediately investigated, to be implemented voluntarily.***

**WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

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

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the plan of care for resident #255 was based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

Interview identified that the resident's sleep patterns and preferences would be assessed by interviewing the resident or their Substitute Decision Maker. The plan of care for resident #255 was reviewed, no assessment of the resident's sleep patterns and preferences was documented.
The plan of care did not include sleep patterns and preferences for resident #255. [s. 26. (3) 21.]

***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 ensuring that the plan of care for each resident is based on an interdisciplinary assessment of the resident's sleep patterns and preferences, to be implemented voluntarily.***

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**WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, was evaluated and updated at least annually in accordance with evidenced-based practices and, if there are none, in accordance with prevailing practices.

The licensee was unable to provide documentation of an annual review of all programs identified in the legislation and confirmed that annual evaluation and updating of the programs was not completed for each program. [s. 30. (1) 3.]

2. The licensee failed to keep a written record relating to an evaluation of the continence care and bowel management program that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The Administrator reported that there was no written record relating to an evaluation of the continence care and bowel management program for 2013, that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. [s. 30. (1) 4.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, are evaluated and updated at least annually in accordance with evidenced-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.***

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**WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices**

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

**s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:**
**4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).**

**s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:**
**5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the restraint plan of care included an order by the physician or the registered nurse in the extended class related to the use of the tilt wheelchair that would prevent the resident from rising and the use of two bed rails with bumper pads when in bed.

Resident #230 was observed to have two full bed rails with bumper pads in place when observed in January 2014.

Review of the medical record was unable to identify an order for the use of full bed rails with bumper pads that prevent the resident from falling from the bed.

Resident #230 was observed to be positioned in a wheelchair that would prevent the resident from rising. Review of the medical record failed to identify an order for the use of the wheelchair.

Interview with registered staff confirmed that there is no order for the use of two bed rails with bumper pads to prevent the resident from rolling out of bed and the use of the wheelchair which would prevent the resident from rising. [s. 31. (2) 4.]

2. The licensee failed to ensure that the restraint plan of care included consent by the resident or if the resident is incapable by the SDM.

The plan of care for resident #230 does include consent for the use of a seat belt but does not include consent for the use of two full bed rails with bumper pads and the use of a wheelchair that would prevent the resident from rising.

Resident #230 was observed in bed in January 2014 with two full bed rails with bumper pads in place.

Resident #230 was observed positioned in a wheelchair with a lap belt in place in January 2014.[s. 31. (2) 5.]

***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 ensuring that the restraint plan of care included an order by the physician or the registered nurse in the extended class and consent by the resident or if incapable the Substitute Decision Maker, to be implemented voluntarily.***

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**WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping**

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

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

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**Findings/Faits saillants :**

1. The licensee failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours as part of the organized program of housekeeping

Bathrooms in specified rooms all had lingering offensive odours.

The Substitute Decision Maker (SDM) of resident #230 identified lingering, offensive odours, in the vicinity of a specified room. The SDM was observed wearing a mask and confirmed in interview that the odours from air fresheners used in the home were offensive and unbearable to them.

Interview with the Maintenance Manager revealed that the home does not have a policy or procedures to direct staff to address incidents of lingering offensive odours. (192) [s. 87. (2) (d)]

***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 ensuring that procedures are developed and implemented for addressing incidents of lingering offensive odours as part of the organized program of housekeeping, to be implemented voluntarily.***

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**WN #20: 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. (2) The licensee shall ensure that a documented record is kept in the home that includes,**
**(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).**
**(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).**
**(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).**
**(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).**
**(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).**
**(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).**

**s. 101. (3) The licensee shall ensure that,**
**(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).**
**(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).**
**(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that the documented record of complaints, kept in the home includes every date on which any response was provided to the complainant and a description of the response, and any responses made by the complaint.

A review of the complaints received through 2013 identified that the documented record of complaints does not consistently include every date on which response was provided to the complainant, a description of the response and any response made by the complainant. [s. 101. (2)]

2. The licensee failed to ensure that documented record of complaints received is reviewed and analyzed for trends at least quarterly.

Documentation review and interview confirm that the complaint record is reviewed and analyzed annually by the home.

The policy related to Concerns, Complaints and Suggestions dated January 14, 2014 and provided by the home on January 15, 2014 indicates that a review of concerns, complaints and suggestions will be completed annually in January. [s. 101. (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 ensuring that the documented record of complaints, kept in the home includes every date on which any response was provided to the complainant and a description of the response, and any responses made by the complaint and that the documented record of complaints is reviewed and analyzed for trends at least quarterly, to be implemented voluntarily.***

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**WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system**

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

**s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee did not have a policy and protocol on the management of benzodiazepines to ensure the accurate storage, destruction and disposal of drugs.

The Director of Care and the Administrator shared that the home is in the process of developing a policy on the storage, destruction and disposal of benzodiazepines as there is an inconsistent practice in the home.

Carded benzodiazepines were observed loosely stored in the bottom drawer of the second floor medication cart and were secured in the double locked narcotic bin in the first floor medication cart.

Interview with Registered Staff confirmed that the home does not deal with the controlled substances consistently as second floor did not lock all controlled substances and first floor did lock all the controlled substance. [s. 114. (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 ensuring that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home, to be implemented voluntarily.***

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**WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

On January 13, 2014 at 1052 hours two insulin cartridges (Novolin ge Toronoto penfill and NovoRapid penfill) were observed in the first floor medication refrigerator, not in the original labeled container or package provided by the pharmacy service provider.

It was confirmed by the Director of Care (DOC) that all medication should be in the original labeled container as packaged by pharmacy.

It is noted that after speaking with the DOC the unlabeled medication was removed from the refrigerator. [s. 126.]

***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 ensuring that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.***

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**WN #23: 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 including the following:

Ensuring that a monthly audit is 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.

The Director of Care (DOC) was unable to provide monthly audits of daily count sheets.

Record review and interview confirmed that the home did not complete count sheets for all controlled substances and therefore no monthly audit could be completed. [s. 130. 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 ensuring that steps are taken to ensure the security of the drug supply, including 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, to be implemented voluntarily.***

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**WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

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

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A. The medication record and the physician orders both indicated that resident #233 is to get a specified medication one half hour before meals.

The Registered Practical Nurse (RPN) shared that she would have to make two trips per resident if she was to give medication prior to the meal.

The RPN was observed to administer medication to resident #233 at lunch time when the resident was in the middle of their meal and failed to follow the physician's orders.

B. Resident #284 had an order for 2.0 KCAL supplement, give 90 milliliters (mls) orally, three times daily at medication pass for the end of each meal.

The RPN was observed giving 2.0 KCAL supplement to a resident in the middle of resident's meal.

The RPN shared that the supplement should be given after meals but it is difficult for the nursing staff as they would have to make two trips to the resident. [s. 131. (2)]

2. Resident #402 had a physician's order for a specified medication to be given with breakfast and supper.

In January 2014, the RPN was observed providing the medication to the resident after the completion of the meal.

The RPN reported that the resident was an exception and therefore gave the

medication in the dining room upon completion of the supper meal. The physician's order however, indicated for the resident was to receive the medication with the meal. [s. 131. (2)]

3. The licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

The physician's order was written for a specified medication.

The RPN shared that resident #501 keeps their medication by the bedside.

The resident confirmed that they keep the medication close by.

Policy on Medication self-Administration, section M, page 2.24 reads that self administration is permitted if the Physician writes the medication order including in the directions "self administer".

The Registered Nurse (RN) confirmed that there should be an order from the doctor, in order to keep the medication by the bedside. No order is documented for resident #501 to keep medication at the bedside. The RN was observed to check the e-MAR, original order and quarterly review. [s. 131. (5)]

***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 ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

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**WN #25: 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. (2) The licensee shall ensure,**
**(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).**

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

**s. 229. (12) The licensee shall ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunizations. O. Reg. 79/10, s. 229 (12).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that there was a written record of the annual Infection Prevention and Control program evaluation.

On January 16, 2014, the Director of Nursing confirmed that the annual Infection Prevention and Control program evaluation was not completed for the year 2013. [s. 229. (2) (e)]

2. The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program.

On January 8, 2014 a soiled incontinence product was observed to have been left on the counter, in the bathroom shared by residents residing in specified rooms, for a period greater than one hour. A visitor to the home was observed to have entered the bathroom and residents had access to the bathroom. [s. 229. (4)]

3. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program.

On January 08, 2014 at 1212 hours and on January 10, 2014 at 1200 hours observation revealed that the Registered Practical Nurse failed to wash their hands between residents, while administering medication in the dining room.

On January 10, 2014 the Registered Practical Nurse was observed to take three pills

out, place them in their hand and put them into the applesauce, which was then administered to the resident. [s. 229. (4)]

4. The licensee did not ensure that the staff participated in the implementation of the infection prevention and control program.

Observations made by two Inspectors (#165 and #532) on January 7, 2014 revealed that a PSW and a registered staff did not participate in the implementation of the infection prevention and control program as they did not wear recommended personal protective equipment (PPE) for Contact Precautions when entering the room and interacting with the resident. One staff member was observed to sit on the bed beside the resident.

This was confirmed in an interview with a Registered Practical Nurse who verified that a mask, gown, and gloves are to be worn by any staff in contact with the resident in isolation. [s. 229. (4)]

5. The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program.

On January 9, 2014 staff were observed removing a face cloth from a half full basin of water and wringing the cloth out before using it to wash the face of a resident leaving the dining room at the noon meal.
The basin contained multiple face cloths and various staff working in the dining room would reach into the basin to retrieve a face cloth to be used for hygiene for residents.

On January 14, 2014 at 1715 a basin half full of water was observed sitting on the second shelf of a cart in the first floor dinning room. The basin was noted to contain cold water.

A basin of water with face cloths was observed on January 14, 2014 at 1805 to be sitting on a cart in the 2nd floor dinning room. The basin was observed to be half full of water. On the same date a similar basin was observed in the first floor dinning room and residents were observed having their faces washed with clothes from the basin.

Interview with the Director of Care confirmed that staff are to prepare a basin of face cloths with warm water, near the end of the meal, to be used for cleaning of resident's

hands and faces before leaving the dining room. No policy related to the preparation of the wash clothes is available in the home.

Documentation review of the minutes of the Infection Control Committee address the use of a basin and face cloths, indicating that the face cloths should be moistened with warm water, that there should be no water in the basin and that the basin should be covered to maintain the warmth of the face cloths.

Staff of the home failed to participate in the implementation of the infection prevention and control program by filling the basin with water, resulting in multiple staff reaching into the water in the face cloth basin and potentially contaminating the water. In addition they failed to follow the guidelines for use of face cloths in the dining room as identified by the Infection Control Committee. [s. 229. (4)]

6. The licensee did not ensure that all pets visiting the home as part of a pet visitation program have up-to-date immunizations.

The Activation Manager could not confirm with documentation, the immunization status of the pet visitation program provided by St. Johns Ambulance on January 14, 2014. [s. 229. (12)]

***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 ensuring that there is a written record relating to each evaluation of the infection prevention and control program that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented and that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.***

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**WN #26: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

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

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**11. Every resident has the right to,**
**i. participate fully in the development, implementation, review and revision of his or her plan of care,**
**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee of the long term care home did not ensure that every resident's right to be afforded privacy in treatment and in caring for his or her personal needs was fully respected and promoted.

On January 10, 2014, the Registered Practical Nurse (RPN) was observed administering an aerosol medication to resident #402 at the dinner table.

The registered staff interviewed indicated the resident was finished eating so it was administered.

The inspector observed the treatment administered at the table while the resident's table mate was eating dessert.

It was reported by another resident that registered staff administered aerosol medications at the table during meals even when the resident had food in their mouth. [s. 3. (1) 8.]

2. The licensee of the long term care home did not ensure that every resident's right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care.

On January 15, 2014 at 1805 hours the registered staff were observed to have left the computer screen unlocked and open on the medication cart displaying residents health information while the cart was left unattended. [s. 3. (1) 11. iv.]

3. The licensee of the long term care home did not ensure that every resident's right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care

On January 08, 2014 at 1156 hours, January 10, 2014 at 1155 hours and January 08, 2014 at 1240 hours registered staff were observed to have left the computer screen unlocked and open on the medication cart displaying residents health information while the cart was left unattended.

Registered staff confirmed that they were not aware of the policy in respect to leaving the computer screen on the medication cart open and accessible to others passing by the cart. [s. 3. (1) 11. iv.]

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**WN #27: 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,**
**(h) residents are provided with a range of continence care products that,**
**(i) are based on their individual assessed needs,**
**(ii) properly fit the residents,**
**(iii) promote resident comfort, ease of use, dignity and good skin integrity,**
**(iv) promote continued independence wherever possible, and**
**(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).**

**Findings/Faits saillants :**

1. The licensee of the long term care home did not ensure that residents were provided with a range of continence care products that were based on their individual assessed needs.

Resident #326's admission assessment completed in 2013, and progress notes on admission indicated the resident had some incontinence of bladder, occasional incontinence of bowel and wore a specified continence product prior to coming to the home. The progress note indicated that family will provide the continence product.

Incontinence Management System Request for Resident Reassessment completed in 2013, by staff indicated that the resident would use a specified continence product and family would supply the product.

The administrator reported that they provide a specified continence product for a resident only if one in 24 hours was used however, if a resident required more than one per 24 hours then family would be responsible to purchase the product.

The Administrator confirmed that a range of continence care products was not available based on individual assessed needs of residents. [s. 51. (2) (h) (i)]

**WN #28: 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 failed to ensure that there is a response in writing within 10 days of receiving Resident Council advice related to concerns or recommendations.

Interview with president of Residents' Council and Family Council both indicated that a written response to concerns identified was not received by the Council, from the Administrator. In spite of this, documentation was available indicating that a response was provided.

The minutes of Resident Council meeting for 2013 were reviewed. It was noted that the response received by the Council did not always relate to all of the concerns identified by Residents' Council and documented in the minutes.

The June 17, 2013 meeting minutes identified that the availability of incontinence products was of concern. The response letter written June 18, 2013 does not address this concern

The July 22, 2013 meeting minutes identified that laundry was disappearing. The response letter written July 30, 2013 does not address this concern.

The September 16, 2013 meeting minutes identified that staff were not allowing residents to choose their own bedtime and that the curtains and windows needed to be cleaned. These concerns were not addressed in the September 18, 2013 response received by the Council.

Interview confirms that the home does not consistently respond to concerns identified during Residents' Council minutes within 10 days. [s. 57. (2)]

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**WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production**

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

**s. 72. (2) The food production system must, at a minimum, provide for,**
**(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).**

**Findings/Faits saillants :**

1. The food production system did not include standardized recipes for all menus.

There were no standardized recipes for minced chicken strips, lemon cod and no minced or puree recipes for penne with spinach, tomato and artichoke.

It was noted that the home did run short of minced chicken strips on January 10, 2014. [s. 72. (2) (c)]

**WN #30: 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).**

**s. 85. (4) The licensee shall ensure that,**
**(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).**
**(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).**
**(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).**
**(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the home seeks the advice of the Family Council in developing and carrying out the Satisfaction Survey and in acting on its results.

The minutes of the Family Council were reviewed and did not include discussion related to the Satisfaction Survey.

Interview with the President of Family Council, the staff member assigned to assist Family Council and the Administrator confirmed that Family Council was not asked for advice related to the development and carrying out of the survey or in acting on its results. [s. 85. (3)]

2. The licensee failed to ensure that the licensee made available to the Family Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

Documentation review and interview confirm that the licensee failed to make results of the satisfaction survey available to the Family Council in order to seek advice of the Council about the survey. [s. 85. (4) (a)]

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**WN #31: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service**

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

**s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,**
**(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).**

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**Findings/Faits saillants :**

1. The licensee has failed to ensure that, (b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents.

On January 8, 2014 residents in specified rooms did not have towels in the room or in the closet when checked.(192)

On January 13, 2014, four out of four residents in a specified room did not have towels in the room or in the closet when checked.

The Manager of Housekeeping and Laundry confirmed that residents don't have clean linen readily available to them.

Registered staff and a Personal Support Worker also confirmed that a supply of clean linen, face cloths and towels are not distributed and available to the residents. [s. 89. (1) (b)]

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**WN #32: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes**
**Every licensee of a long-term care home shall ensure that,**
**(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;**
**(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and**
**(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.**

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**Findings/Faits saillants :**

1. The licensee of the long term care home did not ensure that when a resident has taken any drug or combination of drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drug.

Resident #319 was provided analgesic on specified dates in 2014, however; there was no documentation of the resident's response and the effectiveness of the drug in the resident's clinical health record. [s. 134. (a)]

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**WN #33: 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).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that when a drug that is to be destroyed is a controlled substance, it will be done by a team acting together and composed of:
i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
ii. a physician or a pharmacist

Interview with the Director of Care (DOC) revealed that the Pharmacist destroys the discarded benzodiazepines herself and not in the presence of the DOC.

The DOC and the Administrator shared that the home currently is in the process of developing a policy related to the management of benzodiazepines in the home, as there are inconsistent practices in the home. [s. 136. (3) (a)]