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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 18, 2018	2018_751649_0015	017079-18	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Fieldstone Commons Care Community
1000 Ellesmere Road SCARBOROUGH ON M1P 5G2

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

JULIEANN HING (649), ARIEL JONES (566), REBECCA LEUNG (726)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 25, 26, 27, 30, 31, August 1, 2, 3, and 7, 2018.

Complaint inspection log #015875-18 related to cooling requirements and maintenance services was conducted concurrently with the RQI.

During the course of the inspection, the inspector(s) spoke with the Acting Executive Director (A-ED), Acting Director of Care (A-DOC), Director of Programs & Facilitator for Resident Council, Environmental Service Manager (ESM), Registered Dietitian (RD), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), Student Registered Practical Nurse, Maintenance staff, Resident Relations Coordinator, Family Council Representative, residents and family members.

During the course of the inspection, the inspector observed medication administration, reviewed relevant policies and procedures, observed staff to resident interactions, and reviewed residents' health records.

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

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **5 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident.

Resident #005 was triggered for continence care related to an intervention from stage one of the RQI.

Review of resident #005's plan of care indicated no direction was provided to the direct care staff related to the care associated with this intervention.

In an interview, resident #005 stated that the PSW helped them to provide the care every morning and every night before bed.

In interviews, PSW #117 and PSW #118 stated they did not know how often to provide this care to resident #005.

In an interview, PSW #120 stated they provided the care in an identified manner for resident #005 in the evening.

In an interview, RPN #125 provided a description of the care provided by the registered staff and PSW, associated with this intervention. RPN #125 confirmed that they had not been documenting or keeping track of the care provided to resident #005. The RPN confirmed that the resident's care plan, Kardex or POC did not provide directions to PSW regarding the care associated with the intervention for resident #005. [s. 6. (1) (c)]

2. Resident #008 was randomly selected as a result of non-compliance with resident #005. Resident #008 had an identified intervention during day and night time.

Review of resident #008's plan of care indicated no direction was provided to direct care staff related to the care associated with this intervention.

In an interview, resident #008 confirmed that the home's staff did not provide care associated with this intervention and stated that the care related to this intervention was being provided by the staff in the hospital.

In an interview, PSW #122 stated they did not know of the routine schedule associated with this intervention and had not documented the care anywhere.

In an interview, RPN #128 stated that they did not provide care associated with this intervention for resident #008. According to the RPN the nurses and PSWs provided care associated with this intervention for resident #008 sometimes. They did not document the care anywhere and there were no directions provided in the written plan of care regarding the care associated with this intervention for resident #008.

Review of home's policy # VII-D-10.00: Continence Program – Guidelines for Care, current revision: January 2015 did not indicate any guidance or direction related to care of the identified intervention. No proper cleaning and reuse procedure was provided for the identified intervention.

In an interview, A-DOC confirmed that the home's policy did not provide any guidance or direction to the direct care staff regarding the care associated with this intervention and agreed that the plan of care should have provided the directions to the direct care staff regarding the care of the identified intervention for resident's #005 and #008. [s. 6. (1) (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 there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The home has failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

During the RQI, resident #001 triggered for side rails accident hazard. Observations of the resident's bed system by Inspector #726 on July 26, 2018, and Inspector #566 on August 7, 2018, revealed that the resident's bed system included a manual bed with standard mattress, one quarter and one three-quarter length rail. Stage one notes by Inspector #726 indicated the quarter rail was slightly loose and moved from side to side when touched, increasing the distance between the quarter rail and the mattress, which was confirmed by Inspector #566 during stage two of the inspection.

An interview with PSW #105 indicated that the resident used one quarter rail for bed mobility, and while the other rail is up, it is not in use. Both PSW #105 and RPN #104 did not identified any risks associated with resident #001's bed rails or the bed system. During the inspection, the resident was observed to be seated in their room with their mobility device and was not able to be observed in bed by Inspector #566.

A review of the home's 2017 bed entrapment audit indicated that resident #001's bed system failed the zones of entrapment test for zone two, the area under the rail, between the rail supports or next to a single rail support, and zone seven, between the head or foot board and the end of the mattress.

Observations by the inspector of resident #027's on August 7, 2018, indicated that the resident used a manual bed with standard foam mattress. Two full rails were observed in the down position.

An interview with PSW #109 indicated that the resident required one full bed rail to be in the up position when the resident was in bed. An interview with RPN #104 indicated that the resident required one side rail for repositioning when in bed. Neither staff member identified any risks associated with resident #027's bed rails or bed system. No entrapment risk to resident #027 was observed by the inspector.

A review of the home's 2017 bed entrapment audit indicated that resident #027's bed system failed the zones of entrapment test for zone seven, between the head or foot board and the end of the mattress.

An interview with the home's A-ED confirmed that residents #001 and #027's bed system failed the bed entrapment audit conducted on July 11, 2017, and that there had not been any steps taken since to prevent residents entrapment risk.

Further review of the home's 2017 bed entrapment audit indicated that the majority of beds on each home area were identified to have failed the zones of entrapment test.

The A-ED confirmed that the majority of beds on an identified unit failed the audit, and nothing had been implemented by the home in the immediate or short-term to mitigate the risk to residents using bed rails. They stated further that the home is undergoing a project to eliminate bed rails in the home, however, that it was taking longer than anticipated to complete and at this time only two and a half units approximately had completed assessment under this project. The A-ED confirmed that all bed systems that failed the entrapment audit on four units have not been followed up on further at this time to prevent entrapment risk for the residents that require bed rails. [s. 15. (1) (b)]

2. Resident #004 was triggered for potential side rail restraint from stage one of the RQI.

Review of Resident Assessment Instrument-Minimum Data Set (RAI-MDS), diagnoses, physician order, family consent form, and plan of care, as well as staff interview and resident observations indicated that the two three-quarter side rails were used as personal assistance services device (PASD) for bed safety.

On July 30, 2018, at 0835 hours, the inspector observed resident #004 lying in bed

sleeping with two three-quarter side rails engaged on both sides of the bed. Resident #004 was sleeping on an identified mattress. The inspector observed the space between the identified mattress and the side rails, and the space between the bed frame and the side rails appeared to be wide enough to put the resident at potential risk for bed entrapment of limbs and arms. Resident #004 was observed sleeping in bed, no agitation noted and no immediate risk observed.

Review of the Bed Safety – Sleep Observation records in Point of Care (POC) between July 25 to Aug 7, 2018, indicated that resident #004 was capable of moving by themselves in bed based on the staff's observations.

In an interview, RPN #131 stated that resident #004's family was insistent on having bed rails for fall prevention despite the home's explanation regarding dangers of bed rails and possible entrapment. RPN #131 confirmed that the space between the identified mattress and the side rails, and the space between the bed frame and the side rails appeared to be wide enough to put resident #004 at potential risk for bed entrapment of limbs and arms. RPN #131 stated that the PSWs were supposed to have filled the space between the identified mattress and the side rails to prevent bed entrapment. However, during the observation on July 30, 2018, at 1040 hours, the inspector did not observe that the space had been filled between the identified mattress and the side rails. RPN #131 stated that they would speak with the PSWs to ensure the intervention was implemented.

Review of the bed audit result completed on July 11, 2017, for resident #004's previous bed unit with foam mattress, bed frame: regular and bed rail: two three-quarter. Resident #004's bed unit failed the bed audit in Zone 2: both sides fail, and Zone 7: bottom fail. No corrective action had been taken by the home as informed by A-ED.

Resident #004's bed unit was changed when the mattress was changed on an identified date. The A-ED confirmed that the retest of the bed unit was not done as the result would always be worse with an identified mattress.

In an interview, the A-ED confirmed that after the bed audit was completed on July 11, 2017, the home had not implemented any corrective action to resident #004's bed unit until brought to the home's attention by the inspector. [s. 15. (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 where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents was developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat.

The Ministry of Health and Long-Term Care (MOHLTC) received an anonymous complaint alleging that the home's air condition (AC) unit was not working on an identified date, and no fans had been supplied by the home. The complainant stated that the staff had turned the lights off to cool the floor down and only the emergency lights were working.

A review of the home's policy titled Hot Weather – Management of Risk, policy #VII-G-10.10 with current revision date November 2015, states in the event of a heat alert, extreme heat alert, or heat wave, all team members will follow protocols defined in

"Guidelines for the Prevention & Management of Hot Weather Related Illness in Long-Term Care Homes". This guideline directs the home to record the humidex which is a combined reading of the temperature and humidity to better measure how stifling the air feels than either temperature or humidity alone.

A review of the home's records indicated only a temperature log was being completed by the home during the above mentioned date. The home was not documenting and recording the humidity within the home and was therefore unable to determine the humidex reading to better measure how stifling the air felt within the home. As a result of not documenting and recording the humidity, the home had not followed their own policy which directed staff to implement the Guidelines for the Prevention & Management of Hot Weather Related Illness in Long-Term Care Homes.

According to the City of Toronto's website there was a heat warning issued on the above mentioned date. According to the website a heat warning is when the forecast temperature was greater than 31 degrees Celcius and the humidex was equal to or greater than 40 degrees Celcius.

During interviews with the A-ED, Environmental Services Manager (ESM), and maintenance staff #114, they acknowledged that the home had not followed their protocols defined in the "Guidelines for the Prevention & Management of Hot Weather Related Illness in Long-Term Care Homes", as they were not recording the humidity and was therefore unable to determine the humidex in the home when there had been a problem with the AC unit in the home. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat, to be implemented voluntarily.

WN #4: 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 (4.1) A member of the registered nursing staff may permit a nursing student to administer drugs to residents if,
(a) the licensee has verified with the university or college that offers the nursing educational program in which the nursing student is enrolled that the nursing student has received education or training about the administration of drugs as part of the program;
(b) the nursing student has been trained by a member of the registered nursing staff in the written policies and protocols for the medication management system referred to in subsection 114 (2);
(c) the member of the registered nursing staff who is permitting the administration is satisfied that the nursing student can safely administer drugs; and
(d) the nursing student who administers the drugs does so under the supervision of the member of the registered nursing staff.

Findings/Faits saillants :

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

During the RQI a review of the home's medication incident reports was conducted.

Review of a medication incident report indicated that resident #007 received an extra dose of an identified medication on an identified date. The physician, resident involved and substitute decision-maker (SDM) were notified regarding the medication incident. No adverse reaction was reported by the registered nursing staff.

In an interview, the inspector reviewed the medication incident involving resident #007 with the A-ED (previous Director of Care) who confirmed that the registered nursing staff involved did not administer the medication to resident #007 in accordance with the

directions for use specified by the physician.

During the RQI, the inspector made observations of medication administration practices.

Observation by the inspector on July 31, 2018, at 1203 hours in an identified dining room, revealed student RPN #118 administered an identified medication to resident #010 during a medication pass.

Review of the original physician order and last three-month review indicated that resident #010 was prescribed an identified medication by mouth at specified times not at 1200 hours.

In an interview, RN #108 stated that they did not administer the identified medication to resident #010 at the specified time as they needed to do shift report and rounds first at the beginning of shift. RN #108 acknowledged that the registered nursing student had not administered the identified medication to resident #010 in accordance with the directions from the prescribing physician. [s. 131. (2)]

2. The licensee has failed to ensure that a member of the registered nursing staff may permit a nursing student to administer drugs to residents if, the nursing student who administers the drugs does so under the supervision of the member of the registered nursing staff.

During the RQI, the inspector made observations of medication administration practices.

Observation by the inspector on July 31, 2018, at 1203 hours in an identified dining room, revealed student RPN #118 administered an identified medication to resident #010 without supervision from preceptor RN #108.

In an interview, preceptor RN #108 confirmed that student RPN #118 was not supposed to administer medication to resident #010 without supervision from the preceptor RN.

In an interview, both the A-ED and A-DOC confirmed that all student RPNs must be supervised by the registered nursing staff during medication administration procedures. [s. 131. (4.1) (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 to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, that a member of the registered nursing staff may permit a nursing student to administer drugs to residents if the nursing student who administers the drugs does so under the supervision of the member of the registered nursing staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #005 was triggered for continence care related to an intervention from stage one of the RQI.

On July 30, 2018, at 1137 hrs, in resident #005's private washroom, the inspector observed an identified appliance hanging on the towel bar behind the bath towels on the wall with the identified appliance dangling inside a garbage can on the floor.

In interviews, the A-DOC, RPN #125, and PSW #123 confirmed the used identified appliance should not be inside the garbage can and confirmed that the practice was unacceptable. [s. 229. (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 to ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #6: 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, furnishings and equipment were kept clean and sanitary.

Resident #006 was triggered for unclean ambulation equipment from stage one of the RQI.

On July 30, 2018, at 0855 hours, the inspector observed dry brown stains covering an area of approximate 3 inches x 1.5 inches on the right side of the wheelchair cushion towards the front end, and a moderate amount of food crumbs and dust built up on the wheelchair frame, especially on the brake system at the right side of the wheelchair.

On July 30, 2018, at 1422 hrs and 1450 hrs, the inspector observed the same dry brown stains remained on the right side of resident #006's wheelchair cushion cover, and a moderate amount of food crumbs and dust on the wheelchair frame and the right brake system.

Review of the July 2018 wheelchair cleaning schedule and record indicated that resident #006's wheelchair had been cleaned on two previous dates. The night PSWs were responsible for cleaning the resident's wheelchairs as informed by the A-ED.

Review of the home's policy # VII-H-10.30, title: Equipment Maintenance & Cleaning - Nursing & Resident Care, indicated that "all team members will with each use, observe the cleanliness and safety of equipment and clean as required according to Nursing & Resident Care Equipment Cleaning Frequency Schedule."

In interviews conducted with PSW #130, RPN #125 and A-DOC, they confirmed that resident #006's wheelchair needed to be cleaned as there were dry stains on the wheelchair cushion cover and a moderate amount of food crumbs and dust built up on the wheelchair frame.

On July 31, 2018, at 1505 hrs, the inspector observed the same dry brown stains on resident #006's wheelchair cushion cover, and a moderate amount of food crumbs and dust remained on the wheelchair frame and the right brake system.

In an interview, the A-ED informed the inspector that the staff had cleaned the frame of resident #006's wheelchair. When the inspector inquired about the status of resident #006's wheelchair cushion, the A-ED stated that they were not aware of the issue. After looking at the photograph of resident #006's dirty wheelchair cushion as shown by the inspector, the A-ED agreed to follow up the issue with the unit staff. [s. 15. (2) (a)]

WN #7: 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 was 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 was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Resident #005 was triggered for continence care related to an intervention from stage one of the RQI.

Record review in Point Click Care (PCC) indicated that an intervention was initiated for resident #005 on an identified date as prescribed by the physician. No continence assessment was completed at the time when resident #005's continence status changed from incontinent to continent with the implementation of this intervention.

In an interview, RPN #125 stated that a continence assessment should have been completed for resident #005 when the intervention was initiated.

In interviews, RPN #128 and RPN #113 acknowledged that the continence assessment should have been completed when a resident's continence status changed from incontinent to continent with the implementation of the intervention.

In an interview, A-ED confirmed that when a resident who was incontinent of bladder, started this intervention as prescribed by the physician, the registered nursing staff would be expected to complete a continence assessment for this resident as it is considered a change in the resident's bladder continence status. [s. 51. (2) (a)]

WN #8: 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 if the Residents' Council 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.

During the RQI, the inspector conducted an interview with the president of Residents' Council.

Review of the minutes of the Residents' Council meeting held on an identified date indicated that "Concern form is formal address for Management to reply and provide intervention/solution to remedy the Concern within 10 business days."

Review of the four Concern forms initiated by Residents' Council facilitator #127 in the past three months indicated two out of four concern forms with reply from the home were signed by the Vice-President of Residents' Council 12 days after the concern forms were initiated by the Residents' Council facilitator, on the date the Residents' Council meeting was held.

In an interview, Residents' Council facilitator #127 stated that they were not aware that the home was required to respond to the Residents' Council in writing within 10 days of receiving the advice of concerns or recommendations. They thought it was within 10 "business" days. The same issue was acknowledged by the A-ED in another interview. [s. 57. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.

Interview with Family Council representative #100 indicated that the home had not responded to the Council within 10 days about concerns or recommendations raised by the Family Council.

The President of Family Council was not available for an interview during this inspection.

A review of the Family Council meeting minutes indicated the following concerns or recommendations were brought to the home's attention:
-On an identified date, the Family Council expressed concern and raised the question of who was responsible for cleaning and sweeping the balconies, and cleaning of the glass. The Council also questioned why the summer BBQs had been cancelled. These concerns were completed on the Family Council concern and recommendation form and submitted to the department heads five days after the above mentioned meeting.

Further review of the Family Council concern and recommendation forms indicated that both of the above mentioned concerns were responded to by the department heads and the ED 13 days after the above mentioned meeting. The response to the concerns had not been brought back to the Family Council's attention as the next scheduled meeting had not occurred.

Interview with the Family Council Coordinator who was the assistant to the Family Council indicated that they were aware that the Council had to be responded to in 10 days but thought that the 10 days started from when the concern was brought to the department heads. Resident Relation Coordinator acknowledged that Council had not been responded to by the home for the above mentioned concerns. According to the Family Council Coordinator they had reached out to Family Council members asking them to come into the home and sign the home's response to their concerns but no one had come in to do that. Therefore, Family Council would receive the response to their concerns at the next scheduled meeting.

Interviews with the A-ED and the Resident Relation Coordinator acknowledged that the Family Council should have been responded to in writing within 10 days for the concerns/recommendations raised. [s. 60. (2)]

WN #10: 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. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact information of a person designated by the Director to receive complaints; 2017, c. 25, Sched. 5, s. 21 (1)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(g.1) a copy of the service accountability agreement as defined in section 21 of the Commitment to the Future of Medicare Act, 2004 entered into between the licensee

and a local health integration network;
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(l.1) a written plan for achieving compliance, prepared by the licensee, that the Director has ordered in accordance with clause 153 (1) (b) following a referral under paragraph 4 of subsection 152 (1); 2017, c. 25, Sched. 5, s. 21 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the copies of the inspection reports from the past two years for the long-term care home were 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.

The initial tour was conducted on July 25, 2018, as part of the mandatory tasks for the RQI. During the tour, the inspector observed public copies of inspection/order reports were posted inside a file holder mounted on the wall across the reception desk.

The home had not posted the public copy of Order Report and Inspection Report dated January 5, 2018, of the complaint inspection #2018_685648_0001.

In an interview, A-ED stated they were not aware that the home had not posted the public copy of Order Report and Inspection Report dated January 5, 2018, of the complaint inspection #2018_685648_0001.

During the exit debrief meeting the A-ED #110 stated that they had found the two missing inspection and order reports and they had just posted the two reports in the home. [s. 79. (3)]

WN #11: 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 the narcotics and controlled substances storage box within the medication cart was used exclusively for drugs and drug related supplies.

During the RQI, the inspector made observations of drugs stored inside the narcotics and controlled substances storage box within the locked medication cart as part of the mandatory tasks for the RQI.

Observation by the inspector on July 31, 2018, at 1345 hours revealed batteries for a hearing aid were stored inside the narcotics and controlled substances storage box within the medication cart as confirmed by RN #108. [s. 129. (1) (a)]

Issued on this 30th day of October, 2018

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

Original report signed by the inspector.