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 sions 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 19, Mar 24, 2016	2016_277538_0003	000861-16	Resident Quality Inspection

Licensee/Titulaire de permis

MAPLEWOOD NURSING HOME LIMITED
500 QUEENSWAY WEST SIMCOE ON N3Y 4R4

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

MAPLE MANOR NURSING HOME
73 BIDWELL STREET TILLSONBURG ON N4G 3T8

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

NANCY JOHNSON (538), CHRISTINE MCCARTHY (588), INA REYNOLDS (524)

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): January 19, 20, 21, 22, 25, 26, 27, 28, 29, February 1, 2, 2016.

This Resident Quality Inspection was done concurrently with the following Critical Incidents:
Log #003733-14/CI 1049-000010-14 related to allegations of abuse
Log #000348-16/CI 1049-000002-16 related to allegations of abuse
Log #000589-15/CI 1049-000001-15 related to reporting and complaints
Log #030500-15/ CI 1049-000010-15 related to a fall.
Log #009310-15 related to follow-up to CO #002
Log #009313-15 related to follow-up to CO #004
Log #009318-15 related to follow-up to CO #005

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Maintenance staff, Resident Care Coordinator, the Program Manager, one Program Assistant, the Nutrition Manager, two Health Care Aides (HCA), 15 Personal Support Workers (PSW), one Activity Staff, two Dietary Aides, one Laundry Aide, one Housekeeping Aide, one Physiotherapist, four Registered Practical Nurses (RPN), two Registered Nurses (RN), four family members and 40+ residents.

The Inspector(s) also toured all resident home areas and common areas, observed care and activities provided to residents, resident/staff interactions, meal and snack service, medication administration, medication storage area, posting of required information, observed the general maintenance, cleanliness and condition of the home. Reviewed clinical records and plans of care for identified residents, as well as relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
O.Reg 79/10 s. 17. (1)	CO #004	2015_261522_0005	538
O.Reg 79/10 s. 30. (1)	CO #005	2015_261522_0005	538
O.Reg 79/10 s. 8. (1)	CO #002	2015_261522_0005	538

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. 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:
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 has failed to ensure that every resident had the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance in the Act.

Observation of the Medication pass on January 26, 2016, on the first floor dining room area revealed an unattended medication cart with the Electronic Medication Administration Record (EMAR) screen unlocked with resident personal health information accessible.

Interview with the Director of Care on January 27, 2016, confirmed that the expectation of the home was to ensure that every resident had the right to have his or her personal health information kept confidential. [s. 3. (1) 11.]

2. A) Observation on January 20, 2016, of the first and second floor nurses stations revealed resident's hard copy charts were kept behind the counter at the nurse's station. The nurse's stations were not equipped with a locked door and residents' charts were completely accessible from the hallway.

Staff interview on January 20, 2016, with the Director of Care (DOC) confirmed resident's charts were accessible to the public and the nurse's station was often left unattended.

The DOC confirmed that it was the home's expectation that residents' personal health information be kept confidential.

B) Observation on January 20, 2016, of the first floor nurses station revealed shift report was given at the nurse's station and that the resident personal health information (PHI) was audible. The nurse's station was located in a hallway which was frequented by residents, staff, and visitors.

Staff interview on January 20, 2016, with the Director of Care (DOC) confirmed shift report occurred at the nurse's station on the first floor and the resident information was audible.

The DOC confirmed that it was the home's expectation that residents' personal health information be kept confidential. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

Observation of the Century Bath storage room on the second floor on January 19, and February 2, 2016, revealed the storage room door was unlocked, with no staff members in attendance.

Interview with the Administrator on February 2, 2016, revealed that the home’s expectation was that the Century Bath storage room was locked when unattended to ensure that the home was a safe and secure environment for its residents. [s. 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 to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: 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).

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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall 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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

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 provided direct care to the resident.

Observation of an identified resident revealed a specific condition with no intervention in place. Further observation of the identified resident revealed a specific intervention was in place to address the resident's condition.

Record review of the plan of care revealed the absence of documentation related to the

use of the specific intervention. The RAI Coordinator confirmed the absence of the intervention in the resident's plan of care.

The RAI Coordinator confirmed the home’s expectation was that the plan of care set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. 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.

Clinical record review for an identified resident revealed a specific intervention to address the resident's pain.

Review of the progress notes revealed no documented evidence that the intervention was provided to the resident.

A Registered Practical Nurse confirmed there was no documented evidence that the intervention was provided to the resident.

The Director of Care confirmed that it was the home’s expectation that staff follow the care plan to ensure that each resident was provided with the care as set out in their plan of care. [s. 6. (7)]

3. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

A) Record review of the plan of care for an identified resident revealed a physical device was required at a specific time for a resident.

The plan of care directed staff to monitor the physical device hourly for safety and to document the use of the physical device.

Review of the Flow Sheet for the identified resident revealed no documentation on thirty-seven out of eighty-five days (44%) on the day shift and thirty-eight out of eighty-five days (45%) on the evening shift over an 11 week period.

Interview with the Resident Assessment Instrument Coordinator (RAI) on January 25, 2016, confirmed that documentation was for hourly monitoring and that it was the home’s expectation that documentation on tasks should be completed. (524)

B) Record review on January 26, 2016, of the Resident Assessment Instrument, Minimum Data Set (RAI-MDS)revealed an identified resident was to receive oral care twice daily.

Record review on January 27, 2016, for an 11 week period, revealed no documentation for the provision of the oral care as set out in the plan of care 39.7% of the time.

Staff interview on January 27, 2016, with a Registered Nurse (RN) and the RAI Coordinator, confirmed the absence of documentation for the identified resident on the Point of Care (POC) flow sheet.

Staff interview on January 27, 2016, with the Director of Care (DOC) confirmed that it was the expectation of the home that the provision of the oral care set out in the plan of care was documented. (538)

C) Record review of an identified resident's care plan revealed "staff to complete all oral care. Freq: days and evenings."

Record review on January 18, 2016, for an 11 week period revealed no documentation of the oral care for the identified resident 16 of 86 days or 19% of the time.

Interview with Resident Care Coordinator (RCC) on January 25, 2016, confirmed that the provision of care set out in the plan of care was not documented.

The RCC confirmed that it was the expectation of the home that the provision of the care set out in the plan of care was documented. [s. 6. (9) 1.]

4. The licensee has failed to ensure that the resident's plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A) Record review of the plan of care revealed an identified resident was to have a specific intervention. Staff interview with Personal Support Worker revealed the identified resident no longer required the intervention.

B) Review of the plan of care revealed an identified resident was receiving a treatment. Staff interview with the Registered Practical Nurse confirmed that the resident no longer

received the treatment.

C) Record review of the plan of care revealed an identified resident had an infection. Interview with the Registered Practical Nurse confirmed that resident no longer had the infection.

Interview with the Director of Care on January 28, 2015, confirmed that the plan of care for the specific intervention, the treatment, and the infection was not updated to reflect these changes. The plan of care was not reviewed and revised when the care set out in the plan of care was no longer necessary. [s. 6. (10) (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 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; that the care set out in the plan of care is provided to the resident as specified in the plan and to ensure that the provision of care set out in the plan of care is documented; that the resident’s plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of the home's "Dishwasher" policy DDM-VI-113 under the Safety and Sanitation section issued October 2003, stated that the "temperatures of wash and rinse water are to be recorded once during the morning, afternoon and evening".

A review of the Dish Machine Temperature record for January 1-28, 2016, revealed wash and rinse temperatures were not always recorded during the morning, afternoon and evening on the following dates:

-January 7, 13, 14, 15, 18, 19, 20, 21, 22, 25, 27, 28, during the morning
-January 4, 12, 15, 18 during the afternoon
-January 1-28 no wash and rinse temperatures were recorded during the evening.

Interview with the Nutrition Manager on January 29, 2016, confirmed the expectation that policies and procedures that were put in place were to be complied with and that wash and rinse temperatures were to be recorded as per Dishwasher policy. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident of the home was restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

Observation during a specified time period of an identified resident revealed the resident was restrained.

Record review on February 1, 2016, of the plan of care revealed the absence of documentation related to the use of a restraint. There was no physician order, monitoring or consent for the use of the restraint for the identified resident.

Interview with the Director of Care (DOC) confirmed that it was the expectation of the home that no resident of the home was restrained by the use of a physical device, unless there was consent and a physician order in place. [s. 30. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no resident of the home is restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36., to be implemented voluntarily.

WN #6: 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 a response was completed in writing within 10 days of receiving Family Council's advice, concerns or recommendations.

Review of the Family Council minutes for the months of April, June and August of 2015, revealed that concerns, including the following issues, had been identified in the month of August:

- “Not having been told that Maple Manor is not air conditioned. Also, there has been the need to provide a heater in a room that is cold.”
- “Hearing aids have been lost, damaged and not maintained with new batteries. It was suggested that there could be a protocol for hearing aids where they are taken by the RN at night, then replaced in the morning.”
- "Residents are often left to brush their own teeth, and it is awkward to do so, it was suggested that food trays be provided like in the hospital.”
- “It was noted that the staff is often shorthanded, in particular on long weekends. Could steps be taken to rectify this situation?”

Despite concerns being identified in writing, there was no documentation to support that a written response was provided to the Family Council.

Interview on January 28, 2016, with the Program Manager and the Administrator confirmed that there was no documented evidence that the licensee responded in writing within 10 days of receiving Family Council's concerns or recommendations. [s. 60. (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 the licensee responds in writing within 10 days of receiving Family Council's advice, concerns or recommendations, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids in the food production system were prepared and served using methods to preserve taste, nutritive value, appearance and food quality.

Observation of the lunch meal service in the second floor dining room on January 19, 2016, revealed the consistency of the pureed cottage cheese was noted to be runny and the pureed fruit and pureed muffin ran into each other when served on the plate compromising the taste, appearance and quality of the menu items.

Observation of the food production area in the main kitchen and staff interviews with the Nutrition Manager and a Dietary Aide on January 29, 2016, revealed staff did not follow the standardized recipe for pureed bread and pureed sausage on a bun.

A) The recipe for pureed bread directed staff to use thirty-one slices of whole wheat bread, margarine and milk and blend smooth until a pudding-like consistency was reached. During production, it was observed that the dietary aide used twenty slices of white bread and blended the bread with a measured amount of milk and no margarine was added. The end product was noted to be runny compromising the taste and nutritive value of the menu item.

B) The recipe for pureed sausage on a bun directed staff to use Farmers German sausage, however, the Dietary Aide used bacon and shared that not enough sausage was ordered. There was no standardized recipe available for pureed bacon on a bun. During production, it was noted an unmeasured amount of bacon was blended with brown gravy; the end product was noted to be runny compromising the taste and nutritive value of the product.

Interview with the Nutrition Manager on January 29, 2016, confirmed the substitution and that not all recipes were available for staff to prepare the menu item.

The Nutrition Manager confirmed the home's expectation was that all food and fluids were prepared using methods to preserve taste, nutritive value, appearance and food quality. [s. 72. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all food and fluids in the food production system are prepared and served using methods to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents’ Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that snack service times are reviewed by the Resident’s Council.

A review of the minutes from Residents’ Council meetings from January 2015 to December 2015, revealed there was no documented evidence that snack service times are reviewed with Residents’ Council.

Interview with a representative from Residents' Council confirmed that the home did not review snack service times with Council.

Interview with the Nutrition Manager and the Director of Care (DOC) confirmed that snack service times were not discussed with the Residents’ Council.

The DOC confirmed that snack service times were to be reviewed with the Residents’ Council. [s. 73. (1) 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 snack service times are reviewed by the Residents' Council, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

**s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of maintenance services there were schedules and procedures in place for routine, preventive and remedial maintenance.

Observation of resident rooms and bathrooms on January 19, to January 22, 2016, revealed multiple area of disrepair including scrapes, scuffs, cracks, holes and gouges in walls, doors, door frames, floors and baseboards, sink and mirror corrosion, and rusty baseboard heaters.

Interview with the Administrator on February 1, 2016, revealed that the home does not have a maintenance plan in place. The Administrator confirmed that the expectation of the home was to have schedules and procedures in place to address the areas of disrepair and damage. [s. 90. (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 be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4): 5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

Record review of Critical Incident #1049-000001-15, revealed that the home notified Public Health related to an outbreak on January 5, 2015. An Enteric disease outbreak was declared by Public Health on January 6, 2015, in which eight residents were affected. The Ministry of Health and Long Term Care received notification of the outbreak on January 12, 2015.

Interview with The Director of Care (DOC) on January 29, 2016, revealed that the Critical Incident was initiated but was not submitted immediately.

The DOC confirmed that it was the expectation of the home to submit Critical Incidents related to an outbreak of a reportable disease immediately. [s. 107. (1) 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 to ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4): 5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act, to be implemented voluntarily.

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 controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Observation of a medication pass on January 26, 2016, revealed an unlocked narcotic bin inside the locked medication cart.

The Registered Staff confirmed that the narcotic box was unlocked.

Interview with Director of Care (DOC)revealed that the expectation of the home was to have narcotics contained in a double-locked system. [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 be implemented voluntarily.

Issued on this 7th day of April, 2016

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

Original report signed by the inspector.