Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Nov 11, 2015	2015_251512_0014	T-1717-15	Resident Quality Inspection

Licensee/Titulaire de permis

HUNTSVILLE LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

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

MUSKOKA LANDING
65 ROGERS COVE DRIVE HUNTSVILLE ON P1H 2L9

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

TILDA HUI (512), GORDANA KRSTEVSKA (600), JOANNE ZAHUR (589)

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): August 4, 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, & 19, 2015.

Additional inspections related to the following Log#s were also completed during this inspection:
1) T-248-14, critical incident,
2) T-1357-14 complaint,
3) T-2502-15 critical incident,
4) T-2642-15 order follow up, and
5) T-1551-14 order follow up.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), co-director of care (Co-DOC), MDS/RAI-coordinator, RN/education coordinator, environmental services manager (ESM), registered dietitian (RD), physiotherapist (PT), physiotherapy assistant (PTA), acting activation manager, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), PSW-private caregiver, residents, family members and substitute decision makers.

During the course of the inspection, the inspector(s) conducted observations in home and resident areas, observations of care delivery processes, review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Resident Charges
Residents' Council
Responsive Behaviours
Skin and Wound Care
Trust Accounts

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

13 WN(s)
6 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. 31. (3)	CO #001	2014_369153_0006	512
O.Reg 79/10 s. 33. (1)	CO #002	2014_369153_0006	600
O.Reg 79/10 s. 71. (3)	CO #001	2015_414110_0001	512

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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that different approaches are considered in the revision of resident #032's plan of care when the care set out has not been effective.

Record review of resident #032's progress notes revealed that the resident had experienced multiple falls in an identified month in 2014. Review of the minutes of the falls committee meeting of the above mentioned month identified that resident #032 had experienced multiple falls with majority of them occurring in the evening shift. Two different mobility aids were provided however resident #032 was not compliant with using these mobility aids and continued to ambulate independently.

Review of the resident's falls incident notes for the identified month in 2014, revealed that on multiple dates, the resident was found on the floor in his/her room between two identified hours in the evening. Review of the resident's written plan of care with completion dates between the identified month when the multiple falls occurred and the next three months, the following falls interventions were identified to be in place:
-ensure environment is free of clutter,
-have call bell within reach when in bed,
-reinforce need to call for assistance,
-resident to wear proper and non-slip footwear.

Interview with the MDS-RAI coordinator confirmed that different approaches had not been considered in the revision of the plan of care when resident #032's care needs changed as result of the multiple falls, and it was the expectation of the home for staff to do so. [s. 6. (11) (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 different approaches are considered in the revision of resident #032's plan of care when the care set out has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Record review of the home's policy titled "Resident Rights, Care and Services - Required Program - falls Prevention and Management Program" revised on March 18, 2015, under the Procedures section, indicated that registered staff will ensure that a resident who has a fall has Head Injury Routine initiated if head injury is evident or if fall is unwitnessed.

Record review of resident #003's progress notes revealed that the resident had a fall on an identified date, at which time the resident sustained a large haematoma on his/her head. Further review of the progress notes and resident’s chart revealed a head injury routine form was not initiated after the resident experienced the fall on the above mentioned identified date.

Interview with the co-director of care (co-DOC) confirmed that the staff is expected to initiate head injury routine on the resident if the resident had an unwitnessed fall or fall resulting in injury. The co-DOC confirmed that a HIR form was not initiated. [s. 8. (1) (a),s. 8. (1) (b)]

2. Review of the home’s policy titled “Medication Management-Narcotics and controlled substances” dated 2013/10/07, under paragraph Procedure indicated that the registered staff will complete a running inventory/count for each narcotic in the home, including the amount on hand, dispensed and remaining each time a narcotic is administered.

Furthermore the policy indicates to retain the individual narcotic count sheet with the medication administration record, in this case, the medication cart.

Observation made on an identified date during the inspection period, at an identified time, revealed discrepancy of one pill between the number of identified narcotic pills in the blister cards and the number recorded in residents' individual narcotic count records for the following residents: #021, #022, #23, #24, #25, #26, and #27.

Interview with registered staff #106 indicated that the identified medications were administered to the identified residents at an identified time three hours prior to the observation made by the inspector. The registered staff indicated that he/she did not sign off the count in the individual resident's narcotic count sheet because he/she did not have the narcotic count sheets on the medication cart at the time. Interview with the co-DOC confirmed that the expectation of the home is for registered staff to sign off the narcotic medication count sheet at the time of each administration. [s. 8. (1) (b)]

3. Review of the home's policy titled " Resident Rights, Care and Services - Required Programs - Falls Prevention and Management - Program", Version two, revised date of March 18, 2015, revealed under the procedure section for registered staff point number four stated:

-will ensure that, in addition, a resident who has fallen, is referred to restorative care and to physiotherapy and/or occupational therapy.

Record review of fall incident notes completed for resident #032 revealed that on two identified dates, the resident had falls and that referrals to physiotherapy and restorative care were not completed as per the home's policy.

Interview with the administrator confirmed that referrals to physiotherapy and restorative care were not completed for the resident after the falls. [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, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident’s money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure when a person has reasonable grounds to suspect the following has occurred or may occur, immediately reports the suspicion and the information it was based to the Director; 2. Abuse of a resident by anyone that resulted in harm or a risk of harm to the resident.

Review of an identified critical incident report revealed a physical altercation occurred between residents #006 and #014 on an identified date and time. Both residents had previous history of identified responsive behaviors. The residents were separated and intervention implemented to manage their behaviors.

A critical incident report was submitted to the Director via the Critical Incident System on an identified date and time, which was three days after the incident occurred. There was no evidence of any report of this incident to the Director by using the after hours reporting phone line.

Interview with the administrator confirmed that the critical incident was not reported to the Director as per the legislative requirement. [s. 24. (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 when a person has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risks of harm, the licensee immediately reports the suspicion and the information it was based upon to the Director, to be implemented voluntarily.

WN #4: 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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident’s health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes:

* any mood and behaviour patterns, including wandering
* any identified responsive behaviours
* any potential behavioural triggers and variations in resident functioning at different times of the day.

Observation made on an identified date and time during the inspection period, revealed resident #009 having his/her lunch on the table in an identified area other than the dining room.

Interviews with PSW staff #127, #128, and #108 indicated the resident displayed an identified responsive behavior in the dining room. PSW’s indicated that a strategy to manage the resident's behavior was to seat him/her in an identified area other than the dining room. The resident is still within eyesight of the staff, so staff can continue to monitor the resident, and encourage the resident to eat when needed.

Record review of the written plan of care revealed no indication that resident had the identified responsive behavior, and there was no intervention set up to address the

behavior.

Interview with the RD confirmed that the resident was placed in an identified area other than the dining room for meals when he/she displayed responsive behavior.

Interview with the DOC confirmed that the care plan should be updated to reflect the resident's identified responsvie behavior and the intervention that was put in place to address the behavior. [s. 26. (3) 5.]

2. The licensee failed to ensure that a registered dietitian who is a member of the staff of the home, completed a nutritional assessment for resident #032 when there was a significant change in his/her health condition.

Record review of resident #032's progress notes revealed that the resident had a fall on an identified date. The resident was transferred to the hospital and returned to the home six days later. Prior to the fall, the resident was receiving an identified diet and texture. Review of the resident's progress notes indicated that the registered dietitian (RD) ordered a change in the diet texture for the resident upon the resident's re-admission to the home, in response to a request from nursing staff following deterioration in the resident's condition.

Interview with the RD revealed she/he had not physically assessed the resident for a change in the diet texture. The RD further stated this was what the nurses had asked for and that the resident's condition was poor. RD confirmed that she/he had not completed a nutritional assessment on the resident after a significant change in his/her health condition.

Interview with the administrator confirmed that it was the home's expectation the RD should have completed a nutritional assessment for the resident upon re-admission to the home from hospital after a fall incident that resulted in a significant change in the resident's health condition. [s. 26. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes: any mood and behaviour patterns, including wandering, any identified responsive behaviours, and any potential behavioural triggers and variations in resident functioning at different times of the day, and that a registered dietitian who is a member of the staff of the home, completes a nutritional assessment for the resident when there is significant change in the resident's condition, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident’s health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: a change of 5 per cent of body weight, or more, over one month.

Record review of resident #009's written plan of care initiated on an identified date, revealed that the resident is at high nutritional risk. Review of records for weight monitoring in point-click-care (PCC) indicated that the resident's weight on an identified date was 5.6kg less than the previous month. Record review revealed no indication of any assessment by the interdisciplinary team to address the issue of weight loss of 5.9 % over one month.

Interview with the RD and the DOC confirmed that resident who has experienced a weight loss of five percent over one month should be assessed and action plan developed at the monthly weight monitoring team meeting. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 residents with a five per cent change in body weight or more over one month are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #6: 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 failed to ensure that drugs are stored in an area or medication cart that is secure and locked.

On an identified date during the inspection period, the inspector observed the medication cart on an identified home area positioned in front of the nursing station unlocked and unsupervised. Registered staff #122 was observed exiting the medication room located behind the nursing station which was not within eyesight of the medication cart.

Registered staff #122 confirmed that the medication cart should have been locked. [s. 129. (1) (a) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or medication cart that is secure and locked, to be implemented voluntarily.

WN #7: 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 every resident has the right to have his/her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential.

Observation made on an identified date during the inspection period, revealed registered staff #104 had left a locked medication cart unattended on an identified home area with the personal health information of resident #001 visible on the electronic medication administration record (eMAR) screen.

Interview with registered staff #104 revealed and confirmed that she/he had left the e-MAR screen visible and therefore had not protected the resident's privacy. [s. 3. (1) 11. iv.]

2. Observation made on an identified date during the inspection period, revealed the medication cart on an identified home area unlocked, and the eMAR screen was left open to resident #012's medication administration record. Registered staff #122 was observed exiting the medication room located behind the nursing station which is not within eyesight of the medication cart.

Interview with registered staff #122 revealed and confirmed that he/she is aware that when the medication cart is left unattended, it must be locked and the e-MAR screen closed. [s. 3. (1) 11. iv.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been assessed by a registered dietitian who is a member of the staff of the home, and had changes made to the resident's plan of care related to nutrition and hydration implemented.

Review of resident #012's progress notes revealed on an identified date, the resident was observed to have altered skin integrity on several areas of his/her body. A skin note in the progress notes entered 17 days later indicated one of the areas of the resident's body was draining fluids and required cleaning and dressing. The note also indicated that a similar altered skin integrity on another area of the resident's body was healed. Seven weeks after the initial identification of the altered skin integrity, the resident was observed with the same altered skin integrity on a third area of his/her body. Ten weeks after the initial identification, it was noted in the progress notes that the altered skin integrity on the third area of the resident's body was still open and requiring cleaning and dressing.

Record review revealed during the time when the resident was first identified with altered skin integrity, there was no evidence of any referral made to the registered dietitian, nor was there any RD assessment conducted for the skin issues.

Interview with the co-DOC and the RD confirmed that there was no referral made to the

RD for the resident's altered skin integrity, and therefore there was no assessment conducted by the RD for the resident on the skin issues. The co-DOC and the RD stated that it was the home's practice to only refer to RD when residents are identified with a particular type of altered skin integrity but not the one exhibited by resident #012. [s. 50. (2) (b) (iii)]

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

Review of resident #012's progress notes revealed on an identified date, the resident was observed to have altered skin integrity on several areas of his/her body. A skin note in the progress notes entered 17 days later indicated one of the areas of the resident's body was draining fluids and required cleaning and dressing. The note also indicated that a similar altered skin integrity on another area of the resident's body was healed. Seven weeks after the initial identification of the altered skin integrity, the resident was observed with the same altered skin integrity on a third area of his/her body. Ten weeks after the initial identification, it was noted in the progress notes that the altered skin integrity on the third area of the resident's body was still open and requiring cleaning and dressing.

Review of the progress notes, wound assessments and the skin assessments in minimum data set (MDS) revealed during two identified periods of time, there was no evidence of any skin and wound assessments being conducted for the resident with altered skin integrity.

Interview with RN staff #103 and co-DOC confirmed that weekly skin and wound assessments were not conducted for the resident when the resident had altered skin integrity. [s. 50. (2) (b) (iv)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents’ Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents’ Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Interview with two representatives of the Residents' Council revealed the home's practice in responding to concerns raised at the Residents' Council meetings. The administrator responds in writing to concerns raised at the previous month's meeting that is read at the next month's Residents' Council meeting. The written response from the administrator is posted in the lobby but the two representatives of the Residents' Council are not informed when the response is posted in the lobby of the home.

Review of the Residents' Council meeting minutes revealed a letter dated February 23, 2015, was drafted in response to the Residents' Council's concerns raised at their meeting on February 9, 2015.

Interview with staff #133 who was the appointed Residents' Council assistant and the administrator confirmed that the home had not been responding to Residents' Council's concerns in writing within ten days as required by the legislation. [s. 57. (2)]

WN #10: 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 the licensee responds in writing within 10 days of receiving Family Council's advice related to concerns or recommendations.

Review of the Family Council's meeting minutes revealed the administrator’s written response to Family Council's concerns raised at the January 29, 2015, meeting was dated February 23, 2015. A second written response to concerns raised at the April 30, 2015, meeting was issued on May 19, 2015. A third written response to concerns raised at the June 15, 2015, meeting was issued on July 15, 2015.

Interview with the Family Council representative revealed that the home's representative acknowledged the Family Council's concerns verbally at the meeting and stated that the administrator would respond to Family Council with a letter.

Interview with the administrator confirmed the written responses to Family Council's concerns were not issued within ten days after the concerns were brought to the home's attention. [s. 60. (2)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents, as a condition of continuing to have contact with residents, had received training related to mental health issues, including caring for persons with dementia.

Record review of education attendance for responsive behavior revealed that only 44 percent of direct care staff had received education in 2014, related to mental health issues, including caring for persons with dementia.

Interview with the RN Education Coordinator, staff #123 indicated not all the staff have attended the training as they are always busy on the floor providing care to the residents. Furthermore he/she confirmed that 56 percent of direct care staff did not receive training on responsive behavior management and care for residents with mental illnesses and dementia in 2014. [s. 76. (7) 2.]

WN #12: 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 has 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 an identified date and time during the inspection period, the inspector observed medication crushed and mixed with apple sauce in a medication cup located in the top drawer of the medication cart on an identified unit. The medication was not in its original labeled container.

Interview with registered staff #106 verified the medication in the cup as a narcotic medication. The staff indicated that the medication was supposed to be administered to resident #021 at an identified time. The resident was not in the home at the time, and staff #106 had planned to destroy the medication, but he/she was waiting for another registered staff to witness and co-sign the wastage. Staff #106 confirmed that he/she should discard the medication soon after he/she became aware the resident was not in the home.

Interview with DOC confirmed that the staff should have destroyed the medication immediately when he/she found out that the resident was not available to take the medication. [s. 126.]

WN #13: 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 the home's staff participate in the implementation of the infection prevention and control program.

On an identified date and time during the inspection period, on an identified home area, the inspector observed unlabeled personal care equipment in a shared residents' washroom which included a hair brush, tooth brush, basin, and an urinal.

On a second identified date and time during the inspection period, on the same identified home area, the inspector observed unlabeled personal care equipment in a second shared residents' washroom which included a tooth brush and a hair comb. An unlabeled bed pan was observed sitting on the metal railing behind the toilet seat.

Interview with PSW staff #102 confirmed that the above mentioned items were not labeled, and they should have been. Interview with the DOC confirmed the personal care equipment were to be labeled with the residents' names. [s. 229. (4)]

Issued on this 4th day of December, 2015

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

Original report signed by the inspector.