Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 9, 2016	2016_298557_0009	019819-16	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

VALERIE PIMENTEL (557), ANGIE KING (644), CECILIA FULTON (618), DIANE BROWN (110), MATTHEW CHIU (565)

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): July 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25, 26 and 27, 2016.

The following critical incidents were inspected:
Log #007185-14, Log #006710-14, Log #030799-15, Log #011657-15, Log #002234-15, Log #030864-15, Log #002779-15, Log #001575-15, Log #000431-15, Log #005606-16,

Log #017093-16 and Log #019125-16 related to allegations of staff to resident abuse.

Log #025764-15, Log #000410-15, Log #011160-15 and Log #019213-16 related to allegations of resident to resident abuse.

Log #004906-14 related to allegations of financial abuse.

Log #001941-14 and Log #031048-15 related to resident falls.

Log #004905-14 and Log #021589-15 related to medication management - missing narcotics.

The following complaints were inspected:
Log #002833-14 related to personal support services, sufficient staffing and dining observations,
Log #016074-15 related to staffing and medications,
Log #003014-15 related to Residents' Bill of Rights,
Log #000884-15 related to training and orientation of food service workers,
Log #002709-15 related to accommodation services - housekeeping related to odors, and
Log #031989-15 related to fall prevention and duty to protect.

Inspector #648 was present during the course of the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Director of Care (C-DOC), Education Coordinator (EC), Registered Dietician (RD), Food Service Supervisor (FSS), Resident and Family Service Coordinator (RFSC), Life Enrichment and Volunteer Coordinator (LEVC), Environmental Service Manager (ESM), Staffing Coordinator (SC), Unit Coordinator (UC), Nurse Manager (NM), Registered Nurse(s) (RN), Registered Practical Nurse(s) (RPN), Personal Support Worker(s) (PSW), Houskeeping (HKG), Physio Therapy Assistant (PTA), Food Service Worker (FSW), Resident(s) and Substitute Decision Maker(s) (SDM).

During the course of the inspection, the inspectors conducted observations of residents and home areas, staff and resident interactions, provision of care, medication administration, infection control prevention and practice, meal and

snack service delivery, reviewed clinical health records, staffing schedules/assignments, minutes of Residents' Council and Family Council meetings, minutes of relevant committee meetings, employee records and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **8 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. 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Review of a Critical Incident (CI), dated June 2016, revealed that an identified staff member spoke to an identified resident in a manner that was disrespectful.

Review of the CI and interview with an identified staff member revealed that in June 2016, an identified staff member was heard and observed by another identified staff member speaking in a disrespectful manner.

This incident occurred in the dining room during the meal service and the above mentioned identified staff members' comments were made in response to the resident requesting a specified intervention for beverages.

Record review revealed that the above mentioned resident had deficits related to memory impairment and when interviewed for this inspection, the resident did not recall the incident.

Review of the identified residents' plan of care revealed that resident is to be provided with a specified intervention for beverages. The care plan had not been followed on this occasion.

Review of the homes' investigation revealed that the identified staff member had admitted to making these statements to this resident. The investigation also revealed that the resident likely did not hear and did not recollect that the comment was made and suffered no negative effects.

The Director of Care (DOC) confirmed that this incident had been investigated and had occurred. The staff member involved had received discipline and training. [s. 3. (1) 1.]

2. Review of an identified CI report, dated November 2015, reported that a PSW treated a resident in a manner that was considered inappropriate while assisting this resident at mealtime.

Record review and interview revealed that in November 2015, that two identified staff member’s witnessed another identified staff member holding a resident's food protector apron over his/her mouth and repeatedly telling him/her to swallow while feeding the resident his/her meal.

The above mentioned resident is cognitively impaired and was totally dependent on staff to feed him/her. The above mentioned identified staff member was not available for an interview during this inspection, however review of the homes’ investigation revealed that an identified staff member had witnessed another identified staff member holding the residents’ apron over his/her mouth and saying to the resident swallow.

Interview with an identified staff member revealed they had witnessed the resident spitting out their food and the identified staff member wiped the apron over their mouth and nose and held it there for what seemed to be a long while. The identified staff member perceived these actions as not gentle, but harsh and disrespectful to the resident.

Interview with DOC revealed that this identified staff member had a history of disciplinary action and confirmed the incident had occurred and that the identified staff member involved had been terminated. [s. 3. (1) 1.]

3. The licensee has failed to ensure that the following rights of residents are fully respected and promoted that every resident has the right to live in a safe and clean environment.

A complaint had been received by the MOHLTC in February 2015, with a concern that a

strong smell had been present in the home for two years. The complainant identified the home had this smell due to contaminated grounds.

Home observations were made between July 13 to 20, 2016. Observations resulted in an identified musty odour, describing it as a rotten smell in an identified room and led into the hallway.

An identified nursing staff member also present confirmed the odour and further identified that residents clothes in their closest will smell when the odour is particularly strong. A substitute decision maker (SDM) of a resident had been present and stated the odour was unpleasant.

Record review of the Environmental Services Maintenance Repair Request book for the year of 2015, revealed eleven incidents of staff submitting complaints regarding the offensive odour and requests to resolve the odour in the identified room.

In 2016, the Maintenance Repair Request book revealed three incidents dated February, May, and June 2016, regarding the offensive odour in the above mentioned room with requests from floor staff to resolve the odour.

Interview with the identified resident revealed he/she had been aware of the odour since moving in and described the odour as rotten-ish and confirmed it had been present throughout the room and closet.

Interview with the SDM of the identified resident described the odour as a mouldy, stagnant and very old grease smell. The SDM revealed he/she had reported the issue to the Administrator, confirming actions had been taken but were unsuccessful in mitigating the odour issue. The SDM revealed that he/she spent less time in the room with the resident due to the offensive odour.

An identified nursing staff member told the inspector that the identified room had a longstanding pungent, putrid odour issue dating back for around three years and he/she reported the odour to the environmental service manager (ESM).

Interview with a second identified nursing staff member described the ongoing odour from the room and the adjacent storage room as a disgusting sludge, buildup smell. This identified staff member further stated the odour had been an issue for many years and revealed the grease traps had been cleaned in the past in an attempt to address the

issue. The identified staff member confirmed the issue had not been resolved.

An identified housekeeping worker told the inspector he/she had noticed the persistent offensive odour in the identified room about a year ago. This identified staff member described the odour as rotten yogurt and confirmed the odour had not been resolved following routine deep cleaning.

A third identified nursing staff member confirmed the persistent odour in the identified room had been there over a year ago, describing the odour as mouldy and mildewey. This identified staff member revealed that prior interventions have not resolved the persistent offensive odour.

A fourth identified nursing staff member confirmed the odour in the room is nasty and sour and that the residents clothing can also carry the odour. This staff member further confirmed that he/she had reported the issue to ESM, the Resident and Family Service Coordinator (RFSC) and the Administrator. This identified staff member confirmed the persistent offensive odour had not been resolved.

An interview with Administrator acknowledged awareness of the persistent offensive odour in the above mentioned room, describing the odour as very unpleasant. The Administrator confirmed bi-annual cleaning of grease traps did not resolve the odour. The Administrator stated the revised intervention for quarterly cleaning of the grease traps was to be implemented following this RQI inspection.

The Environment Services Maintenance Repair request book and interviews with ESM and Administrator confirmed cleaning of the grease traps was last completed in February 2016. Review of the repair request book and staff interviews identified the odour reappeared in May 2016, within an estimated three months of the grease traps being pumped.

Staff, resident, and Administrator interviews confirmed the identified room is not a safe or clean environment for residents to live. [s. 3. (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 every resident was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity and that every resident has the right to live in a safe and clean environment, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

In April, 2016, a referral was sent to the registered dietitian (RD) to assess a resident for nutritional interventions in regards to a skin impairment on a identified resident's body by nursing. The RD assessed the identified resident and confirmed that he/she had a skin

impairment on his/her body. Wound care assessments were completed for the above mentioned resident by nursing on seven days in April 2016, identifying the resident continued to have skin impairment.

The resident had his/her multidisciplinary care conference (MDCC) in April 2016, the food service supervisor (FSS) identified in his/her notes that the resident's skin was intact.

An interview with RD and an identified registered staff member both confirmed the resident had an identified skin impairment on his/her body and at the same time the FSS documented that the resident's skin was intact. An interview with the FSS claimed he/she did not know what skin intact meant but had recorded the term in his/her notes.

The RD and FSS confirmed they did not collaborate with each other in the assessment of the above mentioned resident, so that their assessments were integrated and were consistent with and complemented each other in respect to resident's identified skin impairments. [s. 6. (4) (a)]

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

Record review for an identified resident revealed that in June 2016, the Dementia Observation System (DOS) charting was initiated. Review of the DOS record flow sheet revealed that the charting was incomplete on six identified days in June 2016.

Record review for a second identified resident revealed that in May 2015, DOS charting was initiated. The inspector and co-director of care (Co-DOC) were unable to locate the DOS record flow sheet for a seven day period in May 2016. DOS record flow sheet covering a seven day time period of June 2016, were incomplete on five identified days.

Record review for a third identified resident revealed that for a seven day period in December 2014, DOS charting was initiated. Review of the DOS record flow sheet for a seven day period in December 2014, were incomplete. The DOS record flow sheets which should have been initiated in December 2014, were not able to be located.

Interview with an identified registered staff member confirmed that DOS charting when initiated is usually for a seven day period unless otherwise ordered and that every hour of the observation period is to be documented.

Interview with Co-DOC confirmed that the DOS documentation had been incomplete for the above identified time frames for the three identified residents.
[s. 6. (9) 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 the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, and to ensure that the provisions of care set out in the plans of care are documented, to be implemented voluntarily.

WN #3: 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.

The homes' policy titled "Falls Prevention and Management Program", Effective Date: September 16, 2013, Revised Date: May 27, 2016, states registered staff will ensure that a resident who has a fall, the Fall Follow-up progress note should be completed for at least three shifts following the incident.

Record review of a CI report, dated in January 2014, and the progress notes revealed an identified resident had been walking with difficulty and pain, he/she was sent to hospital and diagnosed with a fractured lower extremity. The resident had a fall earlier in January 2014, and the post-fall assessment indicated no signs and symptoms of pain and injury.

Further review of the progress notes indicated no fall follow-up progress notes had been completed for three shifts following the fall, and the following four entries were made after the incident in January 2014:
-a daily progress note stated the resident was very wobbly when walking, and his/her legs buckled twice,
-a fall follow-up progress note stated the resident was ambulating in the hallways with no problems during the night,
-a daily progress note stated the resident was awake, wandering, walking with a dazed stare looking straight ahead and restless, and
-a daily progress note stated the resident was having great difficulty walking and moving the identified lower extremity.

Interviews with two identified staff members indicated they recollected the fall incident but were unable to recall how the resident walked after the fall. An interview with an identified registered staff member indicated he/she had no recollection of the fall and post-fall monitoring for the resident.

An interview with the DOC confirmed it was the homes' policy that registered staff should complete the fall follow-up progress note for at least three shifts following the fall to monitor the resident. Therefore, it should have been completed in January 2014, for the evening and night shifts and on the following day in January 2014, for the day shift, but it was not. [s. 8. (1) (b)]

2. The homes' policy in the Classic Care Pharmacy manual, titled "Administering and Documenting Controlled Substances", policy number 4.3, revision date November 2015, identified that the dose of the controlled substance is documented on the individual narcotic and controlled drug count sheet and to include the recording of the date and time of administration, quantity administered, the remaining quantity and the signature of the person administering the medication.

In July 2016, the inspector observed during the medication observation and review of an identified residents' individual narcotic and controlled substances drug count sheet revealed his/her narcotic had not been documented as administered at the time of

administration on the residents' individual narcotic and controlled drug count sheet.

An interview with the DOC confirmed the home did not follow the policy by failing to document the administration of the above mentioned residents' narcotic at the time of administration.

The homes' policy in the Resident Care Manual, titled "Resident Rights, Care and Services - Medication Management - Treatment Administration Record", revision date July 24, 2015, identified that all treatments administered shall be documented on the residents' personal Treatment Administration Record (TAR) and failure to sign for the treatment indicates that the treatment was not given and considered a medication error of omission.

Record review of the plan of care for an identified residents' skin and wound protocols, including physician orders and TAR's identified the resident was to receive wound care to his/her identified skin impairment on the identified body part on the day and evening shift. Review of the TAR's identified in July 2016, on five occasions during the evening shift that the TAR's were not signed to indicate the treatment had been administered to the resident.

The DOC confirmed the homes' expectation that the policy is to be followed and the registered staff are to document the treatment as being administered. The registered staff did not document on the identified dates and would be considered that the above mentioned resident did not receive his/her treatment.

The homes' policy in the Classic Care Pharmacy manual, titled "Processing Physician Medication Reviews", policy number 2.6, revision date November 2015, identified that the nurse #1 will process any changes made to the review by the prescriber, Nurse #2 will double check that the changes have been processed, a second policy in the Pharmacy manual, titled "Medication Disposal", policy number 5.8, revision date July 2014, indicates medications for disposal are stored safely and securely in a designated area within the home. A third policy in the Resident Care Manual, titled "Resident Rights, Care and Services - Medication Management - Drug Disposal", revision date of October 7, 2013, identified that the registered staff shall remove any medications that are discontinued.

On July 15, 2016, the inspector observed a caddy containing prescription ointments on an open linen cart exposed in the hallway in an identified home area. Record review of a

residents' Physician Medication Review revealed that the resident's prescription ointment had been discontinued in May 2016, and the prescription ointment was not removed from the treatment caddy and discarded.

An interview with the education coordinator (EC) and the DOC confirmed that the homes' policy is to double check the process to ensure when a medication is discontinued that it is removed and stored securely in the medication room and is discarded and that the identified residents' prescription ointment was not removed from circulation, stored and or discarded. [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
- policies regarding Falls Prevention and Management
- that Fall Follow-up notes be completed for at least three shifts following an incident,
- Administering and Documenting Controlled Substances that controlled substance are documented on the individual narcotic and controlled drug count sheet recording the date and time of administration, quantity administered, the remaining quantity and the signature of the person administering the medication at the time of administration,
- Medication Management – Treatment Administration Record that staff are to document the treatment as being completed at the time the resident receives his/her treatment,
- Processing Physician Medication Reviews,
- Medication Disposal and Medication Management – Drug Disposal that the registered staff are to double check the process to ensure when a medication is discontinued that it is removed from circulation and stored securely in the medication room and is discarded appropriately, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 78. Food service workers, training and qualificationsTraining and qualifications

Specifically failed to comply with the following:

78. (1) Every licensee of a long-term care home shall ensure that food service workers hired on or after July 1, 2010, other than cooks to whom section 76 applies,
(a) have successfully completed or are enrolled in a Food Service Worker program at a college established under the Ontario Colleges of Applied Arts and Technology Act, 2002 or a Food Service Worker program provided by a registered private career college and approved by the Superintendent of Private Career Colleges under the Private Career Colleges Act, 2005;
(b) have successfully completed an apprenticeship program in the trade of Cook, Institutional Cook or Assistant Cook under the Apprenticeship and Certification Act, 1998 or the Ontario College of Trades and Apprenticeship Act, 2009; or
(c) have entered into a registered training agreement in the trade of Cook, Institutional Cook or Assistant Cook under the Apprenticeship and Certification Act, 1998 or the Ontario College of Trades and Apprenticeship Act, 2009.

s. 78. (2) The licensee shall cease to employ as a food service worker a person who was required to be enrolled in a program described in subsection (1) if,
(a) in the case of a program referred to in clause (1) (a), the person ceases to be enrolled in the program or fails to successfully complete the program within three years of being hired; or
(b) in the case of a program referred to in clause (1) (c), the registration of the person's training agreement is cancelled, suspended or revoked, or the person fails to receive his or her statement of successful completion of a program under the Apprenticeship and Certification Act, 1998, or certificate of successful completion of a program under the Ontario College of Trades and Apprenticeship Act, 2009, as the case may be,
(i) within three years of being hired, in the case of an apprenticeship program in the trade of Assistant Cook, or
(ii) within five years of being hired, in the case of an apprenticeship program in the trade of Cook or Institutional Cook.

Findings/Faits saillants :

1. The licensee failed to cease to employ as a food service worker, a person who has not successfully completed the required education program within three years of being hired.

Review of the following anonymous complaint during the resident quality inspection (RQI), alleged that many food service workers (FSW) employed at the home had not completed their required education.

Review of employment records for the FSW's and an interview with the FSS revealed that two staff had not met the requirements of the legislation with regards to completion of the program within three years of being hired.

An identified FSW, was hired in 2012, and on the date of the commencement of this inspection they had not completed the required education program within three years of being hired.

Another identified FSW was hired in 2013, and on the date of the commencement of this inspection they had not completed the required education program within three years of being hired.

These findings were confirmed with the FSS and the Administrator.

The employees were both terminated on July 18, 2016. [s. 78. (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 the licensee ceased to employ as a food service worker, a person who is required to be enrolled in a program described in subsection (1) if, (a) in the case of a program referred to in clause (1) (a), the person ceases to be enrolled in the program or fails to successfully complete the program within three years of being hired, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

During the RQI between July 12 and 14, 2016, at identified times, the following observations were made by inspectors #648 and #110 of an identified resident's room:
- a strong lingering odour, suspected to be related to urine, was noted outside an identified room and in the hallway. At this time, an identified physio staff member was providing care to the resident in his/her room. An interview with the identified physio staff member confirmed a lingering offensive odour suspected to be related to urine.
- a resident was observed in his/her bathroom toileting self and a strong lingering urine odour was noted in the resident's room.
- a resident was observed sitting in a chair in his/her room with a persistent strong lingering urine odour present throughout the room and the bathroom. The above mentioned residents' waste basket in his/her room was empty and the toilet bowl in the bathroom was clear.
- an identified registered staff member confirmed the urine odour in the identified room.
- the above mentioned room was observed to have the window open. A charcoal bag was identified on the floor at the head of bed and in the bathroom behind the toilet base. A consistent strong lingering urine odour was present.

Record review of the 2015, Environmental Services Maintenance repair request binder revealed staff requested resolution of the bathroom odour in the identified room in April 2015.

Record reviewed of deep cleaning schedule revealed the above mentioned room had been deep cleaned in June 2016.

Staff interviews revealed the following:
-The identified physio staff member confirmed a strong urine odour in an identified room

at time of interview on a specified date. The identified physio staff member stated this was not unusual for this room.
-Two identified nursing staff confirmed a strong urine odour in the above mentioned room, this odour had been persistent following the resident's initial move to the room one year ago.
-An identified registered staff member confirmed the urine odour in this room.
-An identified housekeeping worker confirmed the presence of a urine odour in the above mentioned room. The identified housekeeping worker confirmed a charcoal bag had been present in residents’ bathroom, for some time to address the odour. The identified housekeeping worker further stated the second charcoal bag was placed under residents’ bed as a result of inspector’s inquiry of lingering odours. The staff reported the urine odour in the room had been noted since the identified resident moved in. The staff further confirmed deep cleaning of this room had occurred in June 2016, however the interventions implemented to date including deep cleaning, had not been effective in mitigating the odour.

An interview with the ESM revealed he/she was unaware of the persistent odour in the room prior to the RQI inspection. The ESM confirmed after speaking with staff the room odour had been ongoing and persistent. The ESM, identified he/she was new to the position as of February 2016.

Record review of Superior Facility Services Environmental Services, Policies and Procedures Manual did not identify an odour mitigation policy for lingering offensive odours. HKG was unable to demonstrate an odour mitigation policy for lingering offensive odours upon request.

The identified housekeeping worker and the ESM all confirmed an unawareness of a policy which included developed procedures to be implemented when addressing incidents of lingering offensive odours in the home. [s. 87. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 92. Designated lead — housekeeping, laundry, maintenance

Specifically failed to comply with the following:

s. 92. (2) The designated lead must have,
(a) a post-secondary degree or diploma; O. Reg. 79/10, s. 92 (2).
(b) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and O. Reg. 79/10, s. 92 (2).
(c) a minimum of two years experience in a managerial or supervisory capacity. O. Reg. 79/10, s. 92 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the ESM designated lead must have the following qualifications: (a) A post-secondary degree or diploma; (b) Knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable.

During the course of the RQI, inspectors interviewed the ESM regarding a verified environmental complaint and an unaddressed lingering odour identified during stage 1 observations.

Record review of the home's ESM job description from the Environmental Services, Policies and Procedures manual acknowledged the legislation requirement for regulation 92, section (2) (a) and (b).

An interview with the ESM confirmed he/she did not hold a degree or diploma from a post-secondary institution. The ESM was unable to demonstrate a reference to access or knowledge of evidence based practices including familiarity with the Ontario Standards Association's Environmental Services documents such as the Ontario Building Code and the Fire Code. The ESM revealed he/she had not received formal training or education in environmental services in his/her current capacity or prior to becoming the ESM for the home.

An interview with the Administrator confirmed the ESM's qualifications did not meet the legislative requirement as identified. [s. 92. (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 ESM designated lead must have the following qualifications:
(a) A post-secondary degree or diploma;
(b) Knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable, to be implemented voluntarily.

WN #7: 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 drugs are stored in an area that is secure and locked.

On July 15 and 19, 2016, the inspector observed a caddy box containing prescription ointments on an open linen cart exposed in an identified hallway in an identified home area. The caddy contained six prescription ointments for four identified residents.

The inspector did not observe any members of the team present or in the vicinity of the linen cart.

An interview with an identified registered staff member, EC and DOC confirmed that the prescription ointments were not stored safely and securely as they were observed on the linen cart which was not contained securely and allowed access to residents. [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 that is secure and locked, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Review of the CI report, dated August 2015, reported a discrepancy in the narcotic count for an identified resident.

In August 2015, an identified residents' individual narcotic and controlled drug count sheet did not match with the number of medication in the blister pack for an identified narcotic. There was one tablet of an identified narcotic that was unable to be accounted for when the evening and night shift completed the shift count.

A review of the plan of care revealed in the progress notes and the vital sign records that

no assessment had been completed for the identified resident by either identified registered staff at 2200 hrs, the time they discovered there was one dose of the above mentioned narcotic missing nor was there an assessment of the resident through the night shift. The identified registered staff did not know whether he/she had lost the one dose of the above mentioned narcotic or whether he/she had accidentally given the resident two tablets at either 1600 or 2000 hrs.

An interview with the DOC confirmed that the two identified registered staff did not take immediate action to assess the above mentioned resident in order to ensure there were no ill effects of potentially receiving two tablets of the identified narcotic at either 1600 or 2000 hrs. [s. 135. (1) (a)]

2. The licensee has failed to ensure that every medication incident involving a resident is documented and reported to the resident, the resident's substitute decision-maker, if any, the prescriber of the drug, the residents' attending physician or the registered nurse in the extended class attending the resident.

Review of a CI report, dated August 2015, reported that after the identified registered staff completed a shift narcotic count that one tablet of an identified narcotic was missing for an identified resident.

In August 2015, the residents' individual narcotic and controlled drug count sheet did not match. There was one dose of the identified narcotic missing from the blister pack when the evening and night identified registered staff did the shift count.

A review of the progress notes for the identified resident failed to indicate neither the attending physician nor the SDM were notified of the potential medication error incident.

An interview with the resident confirmed that he/she was not notified of the potential medication error.

An interview with the DOC confirmed he/she did not know why the above mentioned resident, the SDM or the attending physician were not notified of the medication incident and confirmed they should have been. [s. 135. (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 every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain the resident's health and to ensure that every medication incident involving a resident is documented and reported to the resident, the resident's substitute decision-maker, the resident's attending physician or the registered nurse in the extended class attending the resident, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home is assisted with getting dressed as required and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear.

On July 13 and 14, 2016, the inspector observed a resident wearing a pair of non-slip footwear. One shoe was worn through the top, with a hole that was about one centimeter in diameter.

Record review of the resident's plan of care and minimum data set (MDS) assessment revealed the resident had physical and cognitive impairments and required staff assistance to dress.

An interview with an identified staff member indicated the resident had been wearing the above mentioned footwear for a long time and the shoe was worn out for approximately a

week or two. The staff member further indicated that on an identified day in July 2016, when he/she started the shift in the morning, the resident had been wearing the worn out footwear and the staff member did not change the footwear for the resident.

Interviews with an identified staff member and nursing manager (NM) confirmed since the footwear had worn out and had a hole, the footwear was not appropriate for the resident to wear. [s. 40.]

2. On July 11 and 13, 2016, the inspector observed a resident was wearing a casual zippered pant, the zipper was broken and unable to be closed.

Record review of residents' plan of care and MDS assessment revealed the resident had physical and cognitive impairment and required staff assistance to dress.

Interviews with an identified staff member and an identified registered staff member indicated the resident required staff assistance to setup the clothes for him/her and then the resident would dress self. The identified staff member indicated on an identified day in July 2016, when he/she started the shift in the morning, the staff member put the pants on the bed and asked the resident to put the pants on by him/herself. The staff member was not aware the zipper was broken until he/she saw the resident wearing them. The staff member did not change the pants for the resident.

Interviews with an identified staff member, an identified registered staff member and the NM confirmed that since the pant zipper was broken and could not be zipped up, it was not appropriate for the resident to wear. [s. 40.]

WN #10: 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 respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Record review of the Residents' Council meeting minutes revealed the following concerns were raised during the meetings and no written response was given to the Council.

-On April 18, 2016, several residents expressed that staff members did not knock on the door before entering their rooms, or they knocked and entered prior to a response from the residents.
-On June 20, 2016, residents expressed concerns about wandering residents and the fan was not blowing down the length of the hallway in an identified home area.

An interview with the Residents' Council indicated several concerns were raised during these meetings. The home responded to the Council in writing for other concerns but not the above mentioned.

Interviews with the life enrichment and volunteer coordinator (LEVC) and the Administrator confirmed that a written response was not given to the Council for the above mentioned concerns as required. [s. 57. (2)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

An interview with the Administrator and a review of the homes' current process for determining resident satisfaction revealed the home used the standardized stage 1 questions from abaqis.

Record review of the homes' resident satisfaction survey questions confirmed the sole use of stage 1 abaqis questions.

The Administrator confirmed the current satisfaction survey did not determine satisfaction with all programs and services, such as physiotherapy and continence care. As well, the Administrator was unable to demonstrate a record of the 2015 resident satisfaction survey results. [s. 85. (1)]

2. The licensee failed to seek the advice of the Family Council in developing and carrying out the survey, and in acting on its results.

Interview with an identified member of Family Council revealed the home did not seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

The identified member of Family Council stated the Council had not had the opportunity to review the satisfaction survey or discuss results and provide input towards acting on the satisfaction survey results.

An interview with the Administrator, confirmed the Family Council had not been consulted in the development and carrying out of the satisfactions survey, or acting on the survey results. [s. 85. (3)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

Review of a CI report, dated November 2014, revealed that a written letter of concern regarding the care of an identified resident and written by this residents' family member had been received by the home.

Review of correspondence related to this complaint revealed that on an identified date in November 2014, the DOC had a telephone conversation with the complainant which they followed up with a written letter back to the complainant outlining the concerns and the steps that would be implemented to address concerns raised in the initial letter of complaint.

Review of the CI confirmed that this written complaint was forwarded to the Ministry as required.

Interview with the DOC revealed that they are unable to locate the required documentation of this complaint and are unable to verify if the complaint process was documented as per the legislative requirement. [s. 101. (2)]

WN #13: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): A missing or unaccounted for controlled substance.

Review of a CI report, dated August 2015, reported that an identified resident had a discrepancy in the narcotic count that could not be explained. The CI was submitted six days after the identified date of the discrepancy in August 2015.

An interview with the DOC confirmed he/she had initiated and saved the report but had not submitted the report to the Director regarding the narcotic count discrepancy until six days after. The DOC confirmed the report was not submitted within one business day. [s. 107. (3) 3.]

Issued on this 16th day of February, 2017

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

Original report signed by the inspector.