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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Jan 30, 2015	2014_405189_0005	T-77-14	Resident Quality Inspection

Licensee/Titulaire de permis

NISBET LODGE
740 Pape Avenue TORONTO ON M4K 3S7

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

NISBET LODGE
740 PAPE AVENUE TORONTO ON M4K 3S7

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

NICOLE RANGER (189), SLAVICA VUCKO (210), SOFIA DASILVA (567), THERESA BERDOE-YOUNG (596), TIINA TRALMAN (162)

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): December 15, 16, 17, 18, 22, 23,24,29, 2014 and January 5, 6, 7, 8, 9, 2015.

The following inspection was conducted concurrently with this RQI: T-1586-14.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care(DOC), Director of Human Resources and Staff Educator, Director of Finance, Director of Activation, Director of Food Services (DFS), Infection Control Lead, registered nursing staff, registered dietitian(RD), personal support worker (PSW), dietary aide, activation staff, Resident Council president, Family Council member, residents and families.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care provided to

the resident as specified in the plan.

Resident #09 was identified with a stage 2 skin ulcer on the left lateral foot and was at nutritional risk for weight loss.

Record review revealed that on July 4, 2014, the registered dietitian (RD) recommended 30 ml liquid protein twice daily at medpass until ulcers are healed. On August 28, 2014, the liquid protein was discontinued, as the ulcer had healed.

Record review and interview with an identified registered staff confirmed that the resident's skin ulcer was resolved on August 28, 2014. Further review of the Medication Administration Record (MAR) from October 1 to December 21, 2014, revealed that there was no order for the liquid protein that was provided twice daily to the resident. The registered staff member indicated that pharmacy had in error printed the order for the liquid protein on the MARs for October, November and December 2014. Interview with the RD revealed an awareness that the liquid protein was provided to the resident although there was no order and subsequently the RD discontinued the liquid protein on December 19, 2014.

Record review of resident #09 revealed that Resource 2.0, 30 ml at medpass four times daily was incorrectly transcribed on the MARs for November and December 2014. There was no order or assessment for this intervention. Record review and interview with the RD confirmed that Resource 2.0 was not ordered for this resident. The RD discontinued the Resource 2.0 on December 19, 2014. [s. 6. (7)]

2. Resident #02 is not provided a pureed texture in accordance with the physician's order for regular, pureed diet, dated May 18, 2010.

Resident #02 is identified at risk for aspiration. The resident's written care plan indicates family brings in homemade food. Dietary service offers minced cottage cheese, chopped fine noodles, soft cooked rice, soft crustless bread.

During this inspection the inspector observed the resident to receive regular crustless white bread at breakfast, and homemade rice and protein entrée of minced texture at lunch meals.

Interview with the Director of Food Service (DFS) and the RD confirmed that the resident is at risk for coughing and aspiration. The DFS and the RD revealed that due to the

resident's selective food choices, refusal to eat from the home's menu and dislike of pureed textured modified foods, the resident receives textures other than pureed.

The DFS and the RD confirmed that the resident's current menu and textures provided does not reflect the diet order. [s. 6. (7)]

3. Resident #09 was identified at nutritional risk related to weight loss. On August 29, 2014, the RD requested weekly weights to be taken for one month, and to refer to the RD if further weight loss was noted.

The September 2014 MAR identified to weigh the resident weekly for one month on September 1, 8, 15, 22 and 28, 2014. The resident's weight was not taken on September 1, 15, 22, and 28, 2014. Interview with the RD and the registered staff member confirmed the weights were not taken as ordered. [s. 6. (7)]

4. Resident #02 was identified at nutritional risk related to weight loss. On September 19, 2014, the RD requested the resident be weighed weekly for one month, and to refer to the RD if further weight loss was noted.

The September and October 2014 MARs identified weight to be taken on September 23, 30, October 7, 14, and 21, 2014. Resident #02's weight was not taken October 7, 2014. Interview with the RD and the registered staff member confirmed the weights were not taken as ordered. [s. 6. (7)]

5. Resident #01 was identified at nutritional risk related to weight loss. On October 23, 2014, the RD documented as a plan, for the staff to weigh the resident weekly for one month, and refer to the RD if further weight loss was noted. This was not transcribed onto the October and November 2014 MARs and weights were not taken. Interview with the RD and a staff member confirmed the weights were not taken as ordered. [s. 6. (7)]

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 care set out in the plan of care provided to the residents as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #14 was protected from abuse by anyone.

Record review and staff interviews revealed that from June 22 to October 29, 2014, staff had witnessed resident #14 to be verbally and physically abused by the resident's spouse. Staff indicated that on multiple occasions, the resident's spouse was witnessed slapping, yelling and force feeding the resident.

On one witnessed occasion in June 2014, staff member A reported an incident where the resident's spouse slapped the resident in the hall way and the resident became tearful. Staff member reported that this is an ongoing witnessed behaviour of the spouse.

On one witnessed occasion in July 2014, staff member B reported that he/she was in the dining room assisting residents with the meals when a visiting family member approached the staff and informed that he/she witnessed the resident's spouse hitting and force feeding the resident. Staff member B reported to the registered staff who also witnessed the same.

On one witnessed occasion in October 2014, a family member wrote a letter of complaint to the Executive Director that he/she witnessed, along with staff and other residents, the spouse physically and emotionally abusing the resident. The family member witnessed the spouse roughly grabbing and squeezing the resident's face, slapping his/her right arm and yelling at the resident to eat. The family member indicated this behaviour was "frightening to watch and the resident does not deserve to be treated this way".

An interview with the Director of Care revealed that in July 2014 he/she had a discussion with the resident's spouse regarding inappropriate behaviours towards the resident. The Executive Director revealed upon receipt of a complaint letter on October 29, 2014, further action was taken to prevent the resident's spouse from feeding the resident.

Interviews with 8 staff members who witnessed these abusive incidents reported this is an ongoing issue with the spouse. Staff members reported that they had spoken to the spouse about his/her inappropriate behaviour. [s. 19. (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 residents are protected from abuse by anyone, 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 failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm immediately reported the suspicion and the information upon which it was based to the Director.

Record review and staff interviews revealed that from June 22 to October 29, 2014, resident #14 was observed on multiple occasions by 8 staff members to be verbally and physically abused by the spouse. The staff did not report these incidents to the Director. [s. 24. (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 person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm immediately reported the suspicion and the information upon which is was based to the Director, to be implemented voluntarily.

WN #4: 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. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received retraining annually related to the following: the home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24 and whistle-blowing protection.

Review of staff training records and interview with the Director of Human Resources confirmed that 28 percent of staff did not receive training in 2013 on the home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24 and whistle-blowing protection. [s. 76. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff has received retraining annually related to the following: the home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24 and whistle-blowing protection, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff are provided training in skin and wound care.

Record review of skin and wound care training records and interview with the Director of Human Resources and Staff Education confirmed that 29 percent of staff did not receive training in 2013 on skin and wound care. [s. 221. (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 direct care staff are provided training in skin and wound care, to be implemented voluntarily.

WN #6: 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. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the designated staff member who co-ordinates the infection prevention and control program has education in infection prevention and control practices including: infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management.

Interview with the designated lead for the home's Infection Prevention and Control program confirmed that he/she does not have the required education in infectious disease, cleaning and disinfection, data collection, trend analysis, reporting protocols and outbreak management. [s. 229. (3)]

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

Record review of the home's policy number IC 9.7.13 Management of Methicillin Resistant Staphylococcus Aureus (MRSA) and interview with the DOC directs staff to keep residents on isolation precautions until three negative culture results are obtained, one week apart.

Interview with an identified staff member revealed that resident #15 who had MRSA did not remain on isolation precautions, and was removed from isolation precautions after one negative culture result. The identified staff member confirmed that the resident should have remained on isolation precautions until three negative culture results were received. [s. 229. (4)]

3. The licensee has failed to ensure that residents are offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Record review and interview with the designated lead for the home's Infection Prevention and Control program confirmed that residents are not offered immunization against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. [s. 229. (10) 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 residents are offered immunizations in accordance with the publicly funded immunization schedules posted on the Ministry website; ensure that all staff participate in the implementation of the program; that the designate staff member to co-ordinate the program has education and experience in infection prevention and control practices, 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:
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).

Findings/Faits saillants :

1. The licensee has failed to ensure that every residents' right to be treated with courtesy and respect and in a way that fully recognizes his/her individuality and respects his/her dignity is fully respected and promoted.

Record review of the November 2014 Residents' Council meeting minutes revealed that resident #06 reported a concern regarding an identified staff member who did not assist with toileting as requested by the resident. Further review of the Residents' Council meeting form and interview with resident #06 revealed that the resident voided in his/her incontinent product as staff member did not assist with toileting as requested. The resident stated that he/she was not treated with dignity and respect.

Interview with DOC confirmed that the identified staff member did not respond to resident #06's request to be toileted. [s. 3. (1) 1.]

2. On an identified date in August 2014, resident #05 reported that he/she was finishing a meal when asked by an identified staff member to vacate the dining room so the dietary staff can prepare tables for the next meal setting. The resident reported that the manner in which the identified staff member handled the incident did not show courtesy and respect. [s. 3. (1) 1.]

WN #8: 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 home's policy RCS 7.5.35 Dispensing/Receiving Medication, directs the staff to ensure all orders must be verified upon receipt from Pharmacy to Nisbet Lodge.

On the November 2014 MAR for resident #09, Resource 2.0 was written Resource 2.0 30ml at med pass four times daily. According to the MAR, the resident received Resource 2.0 from November 1 to December 19, 2014 when it was discontinued by the RD.

Record review revealed there is no order for Resource 2.0 for the resident. Interview with the Pharmacy revealed that the order for Resource 2.0 was written in error and the order was intended for another resident.

The Charge Nurse and DOC confirmed that the nursing staff did not accurately verify the order and that the resident received the Resource 2.0 in error. [s. 8. (1) (b)]

WN #9: 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:
4. Vision. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on, at a minimum, interdisciplinary assessment of the resident's vision.

Record review and staff interviews revealed that resident #01 was admitted to the home on December 14, 2005, required eyeglasses, and had not worn them since admission. The written care plan revealed that the resident had impaired vision related to Cerebral Vascular Accident and Hypertension. Furthermore, the written care plan requires resident to have a yearly eye exam and to be referred to specialists, if needed.

Record review and staff interviews confirmed that resident #01's vision was not assessed by the interdisciplinary team since admission. [s. 26. (3) 4.]

2. Record review and staff interviews revealed resident #03 was admitted to the home on June 3, 2009, with impaired vision.

Interview with an identified PSW indicated that the resident had eyeglasses up until one year ago, and since then he/she did not have eyeglasses available for staff to apply.

Record review and staff interviews confirmed that resident #03's vision was not assessed by the interdisciplinary team. [s. 26. (3) 4.]

WN #10: 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 wound has been reassessed at least weekly by a member of the registered nursing staff.

Record review and interview with the DOC confirmed that between March 23 to April 14, 2014, weekly skin assessments were not completed for resident #10's coccyx ulcer . [s. 50. (2) (b) (iv)]

2. Record review and interview with the DOC confirmed that weekly skin assessments were completed once for the month of December 2014 for resident #13's ulcers. [s. 50. (2) (b) (iv)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle.

Resident #02's plan of care indicates that the resident is at risk for inadequate nutritional intake due to being a very picky eater.

Record review revealed that the resident's family brings homemade food twice weekly and that the dietary staff will offer the resident homemade food first. If homemade food is not available, the home will cater to the resident's preferred food choices such as alternate non-meat proteins in addition to cooked chopped fine noodles or soft cooked rice or soft crustless bread with butter and jam.

Interviews with identified staff members revealed an awareness of the resident's cultural food preferences, a dislike for pureed texture and the home's current planned menu. Staff confirmed that the resident will eat only homemade foods until the supply is finished and only then will the resident accept and eat specific foods prepared by the home.

Observation and interview with the resident revealed a dislike of the home's menu. Furthermore, the resident indicated a preference for homemade foods brought in by the family.

Interview with the RD and DFS confirmed that resident has a preference for culturally specific food items that are provided by the family, and some specific food items prepared by the home. The DFS and the RD confirmed that the home's current menu does not meet the resident's needs and preferences and that an individualized menu would be appropriate for this resident. [s. 71. (5)]

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 is 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 by the complainant.

On July 14, 2014, a visiting family member reported a concern to the home regarding an incident observed where resident #14's spouse was verbally and physically abusive to the resident.

On October 29, 2014, another visiting family member wrote an email letter of complaint to the Executive Director regarding an incident observed where resident #14's spouse was verbally and physically abusive to the resident.

The home does not have documented records of the above incidents that includes the above mentioned requirements. [s. 101. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that steps are taken to ensure the security of the drug supply, including that all areas where drugs are stored shall be kept locked at all times, when not in use.

On January 7, 2014, at approximately 12:10 p.m., the inspector observed the 3rd floor medication room door ajar. A bottle of shampoo/body wash was used to keep the door open. The inspector observed no registered staff present in the surrounding area.

Interview with the identified RPN who returned from another floor confirmed that the medication door was not closed and locked. Interview with the registered staff and the DOC confirmed that the door to the medication room is to be closed and locked when not occupied or in use. [s. 130. 1.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (1) Every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of,
(a) all expired drugs; O. Reg. 79/10, s. 136 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the medication management system, a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of all expired drugs.

Record review of the home’s policy RCS 7.5.10 Drug destruction and disposal identified that it does not address ongoing identification of all expired drugs.

On December 22, 2014, the inspector observed 39 boxes of expired Fleet enema in the 3rd floor medication supply room. An identified staff member confirmed that the expired medications should not be there. [s. 136. (1) (a)]

Issued on this 3rd day of February, 2015

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

Original report signed by the inspector.