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 sions de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Apr 21, 2016	2016_215123_0004	006994-16	Resident Quality Inspection

Licensee/Titulaire de permis

LIUNA LOCAL 837 NURSING HOME(HAMILTON) CORPORATION
44 HUGHSON STREET SOUTH HAMILTON ON L8N 2A7

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

QUEEN'S GARDEN
80 Queen Street North HAMILTON ON L8R 3P6

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

MELODY GRAY (123), CAROL POLCZ (156), CATHIE ROBITAILLE (536), LESLEY EDWARDS (506)

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): March 8, 9, 10, 11, 14, 15, 16, 17 & 18, 2016

The following complaints were included in this inspection: #015790-15 related to improper care; #022266-15 related to dietary issue and the home not having an Administrator; #023330-15 related to meal service and shortage of supplies; 026511 -15 related to alleged sexual abuse; 026663-15 related to responsive behavior and 031216-15 related to improper care.
The following Critical Incidents were included in this inspection: #017964-15 related to resident choking; #020373-15 related to alleged financial abuse; #001618-16 related to alleged physical abuse and neglect; #003089-16 related to responsive behaviors; #004810-16 related to alleged physical abuse and #005762-16 related to improper transfer.

During the course of the inspection, the inspector(s) spoke with residents; family members; Personal Support Workers(PSWs); registered staff members; dietary staff members; environmental staff members; program staff members; Administrator; Director of Care(DOC); Assistant Director of Care(ADOC); Food Services Manager(FSM); Resident Assessment Instrument Coordinator(RAI-Coordinator); Program Manager; Corporate Dietary Consultant and the Regional Nurse Consultant.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
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.
- **12 WN(s)**
- **10 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
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2015_188168_0015	123

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care as evidenced by:

The record of resident #061 was reviewed. It was noted in the Progress Notes that in October 2015 the resident's diagnostic test result was elevated. The physician was contacted and gave directions to push water and to monitor.
The next day, the resident's diagnostic test results were noted to be elevated on five occasions and care was provided as per the physician's directions.
The following day, the resident's diagnostic test reading was documented as "HI" . The resident was transferred to hospital and their substitute decision-maker was informed of their transfer. The documentation indicated that the resident's substitute decision-maker expressed concerns including; the resident had increased diagnostic test results over the weekend and had to be sent to the hospital. The concerns were reported to the Director of Care(DOC).

There was no documentation found in the resident's record which indicated that the resident's substitute-decision maker was informed of the resident's elevated diagnostic test results and the physician's directions prior to the resident's transfer to the hospital.

The DOC was interviewed and confirmed that the resident's substitute decision-maker, was not given an opportunity to participate fully in the development and implementation of the resident's plan of care related to the elevated diagnostic test results. [s. 6. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the residents' plans of care, 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 failed to ensure that the home's policy on complaints was complied with as evidenced by:

The home's policy "Complaints" policy number: LTC-CA-WQ-100-05-08, effective date: February 2008, last revision date: January 2016 stated: Verbal complaints that cannot be resolved within 24 hours after receipt will be fully investigated with the written Investigation Report and Complaint Communication Log being completed.
The home's 2015 Complaint Communication Log was reviewed for two verbal complaints received by the home in July 2015 involving residents #013 and #041 and the information was not found.

The Administrator was interviewed and confirmed that at that time the complaint investigation reports were not being completed as per the home's policies and procedures [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 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,is complied with, to be implemented voluntarily.

WN #3: 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 failed to ensure that residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff as evidenced by:

The residents' records and the home's records were reviewed and it was noted that:

A. In September 2015 a Personal Support Worker(PSW) #231 witnessed sexually inappropriate touching between resident #020 and resident #006 in the hallway after lunch. It was noted that resident #020 had a previous incident of displaying this type of behavior as confirmed by the resident's record. Resident #006 had significant cognitive impairment and was not able to defend themselves and was unable to consent.
i. Registered staff #252 met with resident #020 later that day and talked to the resident about the incident of inappropriate touching and discussed interventions that would be implemented to prevent a recurrence of sexually inappropriate behavior. The interventions that were implemented were every 15 minute checks for three days and to monitor residents while in the dining room or hallway.

B. In September 2015 one week after the above incident, PSW #160 witnessed sexually inappropriate touching between resident #020 and resident #006 in the dining room. Resident #020 was sitting at the dining room table when PSW #160 observed resident #006 approach the table where resident #020 was seated. Resident #020 reached out and touched resident #006 in a sexually inappropriate manner. PSW #160 left the dining room to find another co-worker to witness the event, but could not find another co-worker and then returned and redirected resident #006 away from resident #020.
i. The DOC met with the resident the next day to discuss the incident and the interventions that were put back in place which were every 15 minute checks and to separate residents if they were together. The following day, the police were informed of the allegation of sexual abuse.

C. In October 2015 staff member #280 witnessed sexually inappropriate touching between resident #020 and resident #006 in the dining room. Resident #020 was seated at their dining room table and when the staff member entered the dining room, resident #006 was standing at resident #020's table. The staff member observed the residents for approximately one minute and then resident #020 touched resident #006' in a sexually inappropriate manner for 30 seconds. The staff member immediately separated the residents.

The DOC was interviewed and confirmed that resident #006 could not consent to the inappropriate touching and was not protected from abuse by resident #020. [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 all residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's policy on Personal Assistance Services Device(PASD) was complied with as evidenced by:

The home's policy "PASD" policy number: LTC-CA-ON-200-07-18, effective: May 2012, last revision date: July 2014 stated: Ongoing the need for the PASD will be addressed during quarterly reviews of the resident status, with any change in resident status and on an annual basis during the comprehensive review.
The records of residents #009 and #003 were reviewed. Documentation of the annual comprehensive review was not found in the residents' records.
The Administrator was interviewed and confirmed that the PASD policy and procedures were not complied with as there were no annual comprehensive reviews completed in 2015. [s. 29. (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 the written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 4. The licensee did not keep a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented as evidenced by:

A review was completed of the abuse prevention; restraints; skin and wound and fall prevention program evaluations. It was identified that each evaluation did not include the date the evaluation was completed. It was also noted, that the evaluations did not identify the dates that any changes were implemented. The evaluations only identified the target dates for completion.
This was confirmed by the Administrator during interview. [s. 30. (1) 4.]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented as evidenced by:

The record of resident #021 was reviewed. It was noted that in February 2016 the resident was complaining of pain during a transfer. At that time the resident had an undiagnosed fracture. PSW #235 reported to the nurse on duty that the resident was having pain and requested pain medication.
Registered staff #215 was interviewed and reported that the PSW informed them that the resident was experiencing pain. The registered staff assessed the resident and the resident denied any pain. The registered staff confirmed that they did not document the pain assessment in the resident's record. [s. 30. (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 following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented; and that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident fell, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls as evidenced by:

A. In January 2016, resident #006 had an un-witnessed fall. The Progress Notes were reviewed and included a description of the event and the assessment of the resident. The resident's record did not include a post-fall assessment using a clinically appropriate assessment instrument.
The DOC was interviewed and confirmed that a post-fall assessment using a clinically appropriate assessment instrument that was specifically designed for falls was not conducted. [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented as evidenced by:

The February 2016 Minimum Data Set(MDS) Assessment for resident #023 indicated the resident was incontinent of bowel and incontinent of bladder. A review of the resident's plan of care, Resident Assessment Protocol(RAP) and written care plan was completed and they did not include measures to promote and manage bladder and bowel incontinence.
Registered staff #141 was interviewed and they confirmed that resident #023 did not have an individualized plan, as part of their plan of care, to promote and manage bladder and bowel incontinence. [s. 51. (2) (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, each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the programs included a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter as evidenced by:

A) The record of resident #001 and the monthly weight book were reviewed and it was noted that a weight was not taken or recorded for the month of November 2015 as confirmed during interview with the Regional Nursing Consultant.

B) The record of resident #080 and the monthly weight book were reviewed and it was noted that a weight was not taken or recorded for the month of September 2015 as confirmed with registered staff #252.

C) The record of resident #081 and the monthly weight book were reviewed and it was noted that a weight was not taken or recorded for the month of August 2015 as confirmed with PSW #227. [s. 68. (2) (e) (i)]

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 programs include, a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter, to be implemented voluntarily.

WN #9: 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 failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated: 1. A change of five per cent of body weight, or more, over one month as evidenced by:

The record of resident #005 was reviewed including the resident's weight record. It was noted in November 2015, that the resident had a change of five per cent of body weight, or more, over the previous month. There was no documentation found indicating that the resident was assessed using an interdisciplinary approach and that actions were taken or that outcomes were evaluated as a result of the resident's weight change at that time. A dietary referral related to the resident's status including weight loss dated January 2016 was found in the resident's record.

The Food Services Manager (FSM) and the DOC were interviewed and they confirmed that the resident had a weight change of five percent or more, over one month as noted on November 1, 2015. They also confirmed that the weight change was not assessed using an interdisciplinary approach; that actions were not taken and outcomes were not evaluated at that time. [s. 69. 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 with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: A change of five per cent of body weight, or more, over one month, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the planned menu items were offered and available at each meal and snack as evidenced by:

In August 2015, an identified dietary staff member, on an identified home area failed to offer the pureed texture meat to residents on a pureed textured diet. The planned menu items were prepared, however, staff failed to call down to the kitchen for additional pureed meat and residents were not offered the menu item as confirmed during interview with the Program and Support Services Manager(PSSM). [s. 71. (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 the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident as evidenced by:

Resident #002 was observed to have one half bed rail up on the left side of their bed and one quarter bed rail up in the transfer position on the right side of the bed throughout the inspection.
PSW #167 was interviewed and confirmed that both the bed rails were used by the resident and that they were to be up at all times when the resident was in bed. The resident used one for bed mobility and the other for their table and accessing the television converter.
The resident was interviewed and reported that they used the bed rail on the left for bed mobility not the one on the right.
Picture logo posted above the resident's bed showed one bed rail up on the left side of the bed.
The resident's record including the care plan and the Ontario Bed System Assessment completed in April 2015 was reviewed and did not include any information related to the quarter bed rail on the right side of the resident's bed. A bed rail assessment related to the quarter bed rail on the right side of the resident's bed was not found in the resident's record.
The DOC was interviewed and confirmed that the resident #002 was not assessed and their bed system was not evaluated, to minimize risk to the resident in relation to the right bed rail. [s. 15. (1) (a)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug, was provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario as evidenced by:

The DOC was interviewed and reported that some residents and or their families chose to purchase vitamins, supplements, creams, and natural health products at retail establishments other than the home's pharmacy service provider. The DOC also reported that these drugs were not re-labeled; were kept in the home and used by those residents.

The DOC confirmed that the drugs were acquired, received and stored by or in the home and that the drugs were not provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. [s. 122. (1) (a)]

Issued on this 18th day of May, 2016

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

Original report signed by the inspector.