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 21, 2016	2015_289550_0027	O-002874-15	Resident Quality Inspection

Licensee/Titulaire de permis

BRUYERE CONTINUING CARE INC.
43 BRUYERE STREET OTTAWA ON K1N 5C8

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

RESIDENCE SAINT- LOUIS
879 CHEMIN PARC HIAWATHA OTTAWA ON K1C 2Z6

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

JOANNE HENRIE (550), ANGELE ALBERT-RITCHIE (545), LINDA HARKINS (126), LISA KLUKE (547), MELANIE SARRAZIN (592)

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): November 30, December 1, 2, 3, 4, 7, 8, 9, 10 and 11, 2015.

The inspection also included one complaint under Log 003521-15, and three critical incidents under OSAO Log O-001404-15, O-002062-15 and O-002417-15.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Administrator/Clinical Manager, the Director of Care (DOC), the Nurse Practitioner (NP), the RAI/MDS Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), three food attendants, a housekeeper, a sitter, a ward clerk, a volunteer, the President of the Resident Council, the President of the Family Council, family and residents.

In addition, the inspectors reviewed resident health care records, policies related to falls prevention, restraint minimization and complaints and concerns from patients and family, the home's fall prevention program, resident council minutes and family council minutes. Inspectors observed care and services, staff and resident interaction and meal services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation

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

- **25 WN(s)**
- **7 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:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to have his or her

participation in decision-making respected.

Resident #037 was admitted to the home on a specific date in August 2015 with several medical conditions. According to the resident's most recent assessment, it was indicated that the resident was independent with all activities of daily living, as well as cognitively independent for daily decision-making.

During an interview with resident #037 he/she indicated to Inspector #545 that the night staff walked into his room at night with a flashlight and woke him/her up, two to three times to monitor a treatment. The resident indicated that he/she was capable of monitoring the treatment on his/her own. The resident indicated that he/she kept his/her door closed, and did not want to be woken up as he/she had difficulty getting back to sleep once woken up. The resident further added that he/she would call for assistance using the call bell at the bedside if he/she needed anything or if his/her treatment required attention.

A review of the resident's health record was conducted by Inspector #545. In a note documented one day post-admission, it was indicated that resident #037 had requested to be independent with administration of medications. The note indicated that the physician agreed to self-administration of medications to maintain resident's autonomy. Other notes indicate resident's wish to not be disturbed at at night, such as:

-September 6, 2015: a note indicated that the resident had been requesting staff since September 1, 2015 to stop going in his/her room after 21:00 and that he/she would activate the call bell if required assistance

-September 9, 2015: in a meeting with the physician, the nurse and the resident, it was indicated that the resident did not want to be woken up at night, that he/she was taking a sleeping aid medication, and that it would be OK for post treatment interventions to done later in the morning, around 1000 when the resident got up

-September 16, 2015: a note from the physician indicates that the resident understands the risk of not monitoring, continues to refuse to be woken up for post treatment interventions in the morning

-October 10, 2015: night staff indicated that the resident blocked his/her bedroom door to prevent staff from entering, told staff "I am fine" when the nurse knocked on the door to check on the resident

-October 28, 2015: night staff indicated that both doors communicating to the bedroom were closed and barricaded preventing staff from entering resident #037's bedroom

During interviews with RPN #S141 and RPN #S107, they indicated that the resident was independent in all activities of daily living including self-administration of all medications which he/she kept locked in his/her bedroom. The RPNs indicated they were aware that resident #037 did not want to be woken up at night, that he/she was able to independently perform the treatment during the night and do post treatment interventions. RPN #S141 indicated that the resident documented the post treatment interventions on a blank sheet and that the RPN #S141 then transferred the data on the special treatment form left at the bedside. Both RPNs indicated that the night staff had been informed not to enter the resident's room but that they insisted on checking on the resident during rounds during the night shift.

RN #S104 indicated that she was aware that resident #037 did not want staff to enter his/her bedroom at night. She further indicated that night staff were expected to check all residents on rounds during the night shift unless a waiver was signed by capable residents. She indicated that she did not believe that resident #037 had signed a waiver, and further added that she considered that a resident with nightly treatments should be monitored.

In an interview with the Administrator/Clinical Manager, she indicated that she was not made aware of resident #037's request to not be woken up at night for monitoring of the night treatment. She indicated that this resident's right to participate in decision-making regarding sleep and rest pattern at night had not been fully respected and promoted by the night staff on the unit. The Administrator/Clinical Manager, indicated that a resident who barricades himself/herself in his/her room to prevent staff from entering at night poses risk in case of fire, as well as instigating creating anger issues for this resident. She indicated that she would be meeting with the resident and staff to reinforce this right, would provide the resident with a sign to put on the bedroom door to remind staff to not disturb him/her at night. [s. 3. (1) 9.]

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 resident #037's right are being respected by ensuring the resident is no longer disturbed during the night as requested, 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 failed to ensure that there is a written plan of care for each resident that sets out, the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident.

Resident #031 had multiple medical conditions, including paralysis of the a specific limb, dementia and obesity. As per the most recent assessment, the resident was assessed as (a) requiring total care for all activities of daily living, (b) including personal hygiene and toileting, and (c) the resident scored 3 out of 3 on the pain scale indicating he/she

suffered daily severe pain.

(a) Upon review of the resident's plan of care it was documented that the resident had some or all natural teeth, and did not have dentures. It also indicated that the resident was capable of brushing own teeth, and to provide cuing.

Inspector #545 observed resident #031 with an upper and lower full dentures on November 30, December 4, 7 9 and 10, 2015.

On December 9, 2015 Inspector #545 overheard PSW #S102 asking PSW #S137 during morning, if resident #031 had dentures.

On December 10, 2015, PSW #S134 indicated to the inspector that she had not worked on the unit for 4 months and was assigned to resident #031 today. She indicated that the resident had 2 dentures, and required staff to clean and insert the dentures as was unable to. She indicated that she did not have time to read the plan of care, that she asked other staff for directions.

(b) Upon review of the resident's plan of care it was documented that the resident was incontinent, used briefs, required changing of brief every 2 hours and as required and that staff were encouraged to place the resident on a commode when possible. It was also indicated that a mechanical lift was used for all transfers.

PSWs #S113, #S134 and #S137 were interviewed. They all indicated that the resident was incontinent of bladder and bowel and that two staff were required to change the incontinent product, and the resident's being very sensitive to any touch by staff. The indicated that the resident was not transferred to a commode for toileting.

PSW #S108 indicated to the inspector that she had toileted the resident on a commode on occasion for bowel care, but only when the resident was more alert and in a good mood, and usually if he/she complained of pain. She indicated that the resident was very fearful and demanded that PSW remain at his/her side. PSW #S108 could not remember when she last toileted the resident on a commode, indicating that it was a long time ago.

RN #S135 indicated that the resident might have been toileted on a commode when was admitted but that he/she was no longer being toileted as it would be unsafe due to the resident's condition.

(c) The plan of care indicated to administer medication as ordered and to assess effectiveness, as well as to monitor pain and report signs of pain.

Resident #031 indicated to the inspector on December 4, 9 and 10, 2015 that he/she had pain in different area of the body.

Upon review of the resident's medication administration record (MAR), it was documented that pain medication was was administered twice daily, and that another pain medication was ordered as needed, and was administered once between specific dates in December 2015 with good effect.

In a note from the geriatrician on a specific date in August 2015 it was documented that the resident's cognitive impairment made it hard for resident #031 to regulate his/her emotion and to express self. The note also indicated that the resident was certainly exhibiting a fear of pain recalled from before when the resident was being moved during care, which was displayed by distress and vocalization.

During an interview with PSW #S108 she indicated that resident #031 had considerable generalized pain, and she believed that the pain was not well managed. She indicated that the resident was fearful, often screamed when moved during care.

PSW #S137 and #S102 indicated that the resident screamed even before they touched the resident, for example when they told the resident they would pull the blanket off to change him/her, he/she started to scream that they were hurting him/her, and they had not yet touched the resident. Both PSWs indicated that they felt that the resident had generalized pain all over his/her body and they always worried about hurting the resident, even when they were very careful in their approach.

RPN #S121 indicated that resident #031's pain was managed with regular administration of a specific pain medication twice daily. She indicated that she had noticed that when the resident was tired, his/her pain seem to be increased, and that the resident rarely asked to go back to bed to rest but when offered, he/she accepted and usually with good effect.

RN #S135 indicated to the inspector that the resident's pain was partly physical but also psychological, that he/she was properly medicated. She indicated that staff needed to be patient in care provision, talking to the resident while providing care and explaining next

steps.

In an interview with the Administrator/Clinical Manager she indicated that the resident's plan of care was not personalized as it did not include the goals the dental care, bladder care and pain management were intended to achieve; and that clear directions to staff and others who provide direct care to the resident was missing. [s. 6. (1)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #004 related to sleep patterns preferences, mouth care and communication abilities.

Resident #004 was admitted to the home in 2015 with a a specific neurological diagnosis. The resident is alert and oriented to time and place. Resident #004 does present with an altered speech but can clearly express his/her needs with time and patience.

In an interview held on December 1, 2015, resident #004 indicated that he/she wished to go to bed at a specific time in the evening. Also, he/she indicated that he/she does not want to be woken up by the night shift to be put in his/her wheel chair in the early morning to wait for the day staff to start. Resident #004 indicated that it is staff that don't know him/her that will put the resident to bed early in the evening or will get him/her up in the w/c on the night shift. Resident # 004 indicated that if staff had patience and time he/she can make himself/herself understood.

Resident #004 indicated that he/she has own teeth and with proper set up he/she can do own mouth care. On December 7, 2015, interview held with Personal Support Worker (PSW) #S126 and Registered Practical Nurse (RPN) #S127 indicated that they don't know if resident #004 has own teeth or has dentures. They both indicated that resident #004 can express his/her needs and that they can understand him/her if they take the time.

Resident #004 health care record was reviewed. It was noted that no written documentation was found in the plan of care providing clear directions to staff related to resident #004's, sleep pattern preferences, mouth care and communication abilities. [s. 6. (1) (c)]

3. Resident #015 was admitted to the home with a two specific diseases, is paralysed on one side of the body, is alert and oriented.

In an interview held on December 1, 2015, resident #015 indicated that the top denture was loose and keeps falling off. Discussion held on December 7, 2015 after lunch, resident #015 indicated that he/she requires assistance to clean his/her teeth. At that time, it was observed by Inspector #126 that resident's upper front denture was not clean and had food debris.

On December 7, 2015, interview held with Personal Support Worker (PSW) #S126 and Registered Practical Nurse (RPN) #S127 indicated that they don't know if resident #015 has his/her own teeth or has dentures. PSW #S126 indicated that he assisted resident #015 for the morning care, setting the resident up in the bathroom in front of the sink. He indicated that he/she can do own mouth care.

Resident #015 health care records were reviewed and it was documented in the plan of care to "maintain oral hygiene for client daily- *Somes or all natural teeth lost-does not have or does not use dentures (or partial plates), *Daily cleaning of teeth or dentures, or daily mouth care by Client or staff. The expected outcomes and interventions documented in the plan of care does not provide clear directions to staff related to resident's #015 mouth care. [s. 6. (1) (c)]

4. Resident #011 was considered a high risk of falls, and had five falls between a specific date in October 2015 and a specific date in November 2015. RN #S104 changed the pictogram above the resident's bed and the PSW assignment sheet for that specific resident group on a specific date in November 2015 indicating two person side by side assistance for all transfers. RN #S104 indicated on December 9, 2015 that this was a temporary measure until the resident was reassessed by physiotherapy department with a formal transfer assessment. RN #S104 indicated that she did not update the care plan or the basic care flow sheets to identify the change in transfers, as this is only done when the change in transfer is official by physiotherapy.

RN #S104 indicated that she made this change for the resident`s and PSWs' safety, however she is able to assess the needs of the resident and has transferred the resident on her own.

Inspector #547 interviewed PSW #132 who indicated that she was always told to follow the pictogram, and that the resident required 2 person transfer now, however she was aware that other PSWs transferred the resident with one person.

Inspector #547 reviewed the actual care plan with RPN #123, who indicated that he updated this care plan, and that he was not aware that there was a change in the transfers, as he knows that some staff transfer resident #011 by 1 person, and others transfer with 2 people. RPN #123 indicated that he based his changes on the previous care plan, and interviews with PSW staff. RPN indicated that he may have interviewed someone who transfers Resident #011 by 1 person. The residents care plan indicated 1 person transfer for toileting and transfers, and two person assistance for bed mobility. RPN #123 indicated that he is aware that the resident is frustrated about this change in his transfer needs, and the resident 's plan of care does not provide clear directions to staff. [s. 6. (1) (c)]

5. The licensee has failed to ensure that resident #002's plan of care is based on an assessment of the resident and the resident's needs and preferences.

Resident #002 fell on a specific date in the summer of 2015 and sustained a fracture of a specific body part. Inspector #550 reviewed the resident's plan of care and observed there was no indication on the risk for falls for this resident. Inspector #545 observed the resident's health records. A fall risk assessment was completed on October 11th, 2010 and indicated the resident was assessed at a level 3, an actual fall risk. RN staff #101 indicated to the inspector she is the one who should have completed a fall risk assessment for the resident after his/her fall in the summer of 2015 and updated the plan of care to reflect the fall risk but she was away on holidays at the time of the incident therefore it was not done. [s. 6. (2)]

6. The licensee has failed to ensure that the care set out in the plan of care is provided to resident #020 as specified in the plan related to personal hygiene.

From December 1 to December 4, 2015 Inspector #547 noted resident #020 had long facial hair and was pulling at the hair. During these observations the resident expressed that they bothered him/her and he/she had lost their razor.

PSW #123 indicated to Inspector #547 during an interview on December 4, 2015 that he noted the resident had long facial hair and required it to be removed. PSW #124 indicated that the resident did not have a razor and that he/she should have had this done during his/her bath this morning.

On December 4, 2015 Inspector #547 reviewed the resident's care plan currently in use for the resident. It was indicated that the resident required one staff physical assistance

for personal hygiene to remove facial hair daily. Resident #020 received a tub bath on Tuesday and Friday mornings, and was observed to have long facial hair. [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 resident #031's plan of care is revised to include goals and to provide clear directions to staff in regards to pain, incontinence and mouth care, residents #004, #011 and #015's plan of care is revised to provide clear directions to staff in regards to:
resident #004: sleep patterns, communication and mouth care
resident #011: transfers
resident #015: mouth care,
resident # 002's plan of care is based on an assessment of the resident's needs and preferences and resident # 020's care is provided as specified in the plan related to personal hygiene, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home has his or personal items, including personal aids such as toothbrushes, bars of soap, soap dish, bed pan and kidney basin labeled within 48 hours of admission and of acquiring, in the case of new items.

On November 30th, December 1st and 2nd, 2015, Inspectors #126, #545, #550 and # 547, observed on all units of the home the following:
- a total of 11 unidentified toothbrushes on counters in different shared bathrooms
- a total of 16 used bar of soap and soap dishes unidentified on the bathroom counter in different shared bathrooms
-1 bed pan and 2 kidney basins unidentified and kept in different shared bathrooms
-1 roll on deodorant and 2 denture cups unidentified on the bathroom counter in a shared bathroom

Discussion held with RPN #127 that staffs are supposed to obtain a label with the name of the resident and apply it to each respective item. Several PSWs also indicated that each personal item belonging to residents are supposed to be labeled with each resident's name. [s. 37. (1) (a)]

2. The licensee has failed to ensure that each resident has his or her personal items, including personal aids, (b) cleaned as required.

Inspector #547 observed dried brown matter around the inside of the plastic raised toilet seat in the shared bathroom for Resident #011 on December 1,2,4, 7 and 8, 2015.

Inspector #547 interviewed Housekeeper #130 regarding Resident #011's raised toilet seat, and she indicated that she has to clean this toilet seat daily and that the seat is also stained with brown matter. She has brought this raised toilet seat to the basement, to have it power washed, however the stain remains. Housekeeper #130 indicated that there is dried brown matter found on this toilet daily related to another resident who shares this same toilet seat.

Resident #011 indicated to Inspector #547 that the toilet is always soiled with brown matter, and that the toilet is never cleaned properly.

Clinical Manager #117 indicated that Housekeeper #130 usually identifies equipment that is difficult to keep clean or is required to be replaced, however she was not made aware of the situation in this shared bathroom. Clinical Manager #117 indicated that the raised toilet seat has not been maintained clean for the resident's sharing this bathroom. [s. 37. (1) (b)]

3. Inspector #547 observed Resident #027's wheelchair heavily soiled with dried beige matter on the footrests, metal base of the wheelchair and seat belt on December 1,

2015. On December 9, 2015 Inspector #547 brought Clinical Manager #117 observed the dried beige matter on resident #027's wheelchair remained unchanged from December 1, 2015. Clinical Manager #117 indicated that the home has a process for cleaning of all wheelchairs that is done every three months however staff are aware to wipe chairs as they become dirty or if they are heavily soiled as this wheelchair is, that they call maintenance to have it cleaned overnight. Clinical Manager #117 indicated that the state of this wheelchair was not acceptable for Resident #027. [s. 37. (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 all personal items including personal aids are labeled for each resident and resident #11's raised toilet seat and resident #027's wheelchair are cleaned as required, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

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 each resident is offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner and a snack in the afternoon and evening.

During an interview with resident #017 and resident #030 on the 2nd floor (Unit 2AB), they indicated to Inspector #545 that snacks were not consistently offered in the

afternoon and evening.

The President of the Residents' Council indicated to Inspector #547 that the snack service in the afternoon has been canceled a few months ago on the 3rd floor, as the residents were not eating their supper, and due to too much waste, they decided to cancel the snack in the afternoons. The President of Resident's Council further indicated that she often did not get any evening snack either, as she kept her door closed, and staff rarely came in, or knocked, as they passed by her door. The staff are also aware that she often will refuse and ask for water only, but she indicated that it would be nice to be offered that choice, as she did like some of the snacks like crackers and cheese.

On December 4, 2015 at 14:30 and again at 15:00, Inspector #545 observed a fully stacked snack cart in the kitchen of the 2AB unit's dining room. A gray plastic bin was filled with cold water, and jugs of various juices such as apple, cranberry, orange, tomato. There was a jug of water, one nectar apple juice and one nectar orange juice. A bunch of bananas and a ziplock bag with mini muffins were also available on the cart and a large number of clean plastic glasses and napkins.

At 15:30, Inspector #545 walked by the 2AB unit's dining room with the Administrator. The snack cart was untouched in the kitchen, and no glasses had been used. The Administrator indicated that it was possible that the day shift ran out of time and would have assigned the snack pass to the evening shift. At 16:35, Inspector #545 returned to the 2AB unit dining room; PSW #119 was in the dining room pouring juices set in a gray bin with ice on a cart with various juices: apple, cranberry, orange, tomato and nectar apple and nectar orange. She indicated that she had just prepared the cart for dinner service, and that she had not passed the afternoon snack when she started her shift at 3pm, that it was probably passed by the day shift.

RPN #118 indicated that the evening shift had not been requested to pass afternoon snack, therefore it was not passed on their shift.

Food Attendant #120 indicated to Inspector #545 that she had brought the snack cart to the kitchen at the beginning of her shift and that it was the responsibility of the day shift PSWs to pass the collation. She indicated when she returned to the unit at 14:30, the items had been removed from the snack cart and she assumed that the snack had been passed. A ziplock bag of mini muffins and 3 bunches of bananas were found in the cupboards in the kitchen. [s. 71. (3)]

2. The licensee has failed to ensure that planned menu items are offered and available at each meal.

On December 4, 2015 at 0755, Inspector #545 entered dining room on unit 2AB and observed bowls of cold cereal, cut up bananas, opened yogurt containers and beverages: milk, water and orange placed at the settings of all residents in the dining room. Only 5 residents were observed in the dining room at that time.

The Daily Menu indicated that it was day 19, and stewed prunes – bananas, cold cereal / hot cereal, toasts (variety) and scrambled eggs were to be offered.

Inspector #545 observed scrambled eggs served to two residents, and toasts with peanut butter served to five residents. The food items were brought to the residents by the Food Attendant or PSWs.

At 08:25, Inspector #545 observed PSW #111 picking up a small bowl with pureed pruned from resident #050's place setting and giving it to resident #051. She then took another resident's pureed prunes and gave it to resident #047, indicating to this resident that prunes were really good for him/her. She then fed one spoonful standing at the resident's side, then left the dining room.

Food Attendant #115 indicated to the inspector that she had been working there for ten years and knew the residents well and did not need to offer menu items to the residents. She indicated that cereals, yoghurt and bananas, including the beverages were placed on the tables before the residents entered the dining room. She further added that she often worked by herself as the PSWs were busy getting residents up for breakfast.

In an interview with the Administrator, she indicated that it was the home's expectation that staff offer planned menu items to the residents, even at breakfast. She further indicated that there was no reason for staff to place cold cereal, juices, opened yogurt containers and cut up bananas at each resident setting before they entered the dining room, and that all residents should be offered options. She added that she was aware that some staff would say that they know their residents well and do not feel they need to offer, but that residents have the right to be offered, as they could change their minds. [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 residents are offered a between meal beverage in the morning, afternoon and evening, a snack in the afternoon and evening, and are offered meal choices as indicated on the menu, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the weekly menu is communicated to residents.

On December 4, 2015 Inspector #545 observed a weekly menu posted on the wall outside of the dining room on unit 2AB. The Fall/Winter 2016, week 3 (Day 15 to 21) menu indicated the lunch and supper menu for all texture types. The breakfast menu was not found on this weekly menu.

The Administrator indicated to the Inspector that it was the home's expectation that the weekly menu, including breakfast, lunch and dinner be communicated to residents by posting it at the entrance of the dining room on the wall. After reviewing the menu with the inspector, the Administrator indicated that the breakfast menu was missing from the weekly menu, therefore not communicated to residents. [s. 73. (1) 1.]

2. The licensee has failed to ensure that meal service provided in a congregate dining setting unless a resident's assessed needs indicate otherwise.

On December 4, 2015 at 07:55, Inspector #545 observed a bowl of cold cereal, cut up bananas, an opened container of yoghurt, a glass of water, a glass of orange juice and a glass of milk placed at the table where resident #031 and #046 were expected to sit for breakfast in the dining room on unit 2AB.

On that same day at 08:40, Inspector #545 observed PSW #113 feeding resident #031 in his/her bed. The PSW indicated that the Resident was fed breakfast in bed because he/she preferred to stay in bed. RN#101 indicated to the inspector that resident #031 was going to have a bath after breakfast and that it was decided that he/she would stay in bed for breakfast today.

In a review of resident #031's plan of care, it was indicated that resident #031 required encouragement and some assistance for eating, especially when fatigued, that 2 staff members were required at all times for transfers as the resident was transferred via mechanical lift. There was no information indicating that the resident was assessed as requiring feeding in bed.

In a review of the progress notes and 24-hr report, there was no information indicating that the resident required to be fed in his/her room for breakfast on December 4th, 2015.

At 08:50 on December 4, 2015, Inspector #545 observed PSW #114 feeding applesauce to Resident #046, while the resident was sitting up in his/her bed. The PSW indicated that the resident did not want to eat this morning, she picked up the uneaten oatmeal

mixed with yoghurt and the unfinished applesauce and left the room. RPN #107 indicated to the inspector that Resident #046 was agitated and spit while being fed at breakfast in the dining room, therefore it was decided to feed this resident in his/her bedroom to provide calmness in the dining room.

In a review of Resident #046's plan of care, it was indicated that the Resident required extensive assistance for feeding, required assistance of 2-staff for transfers. There was no information indicating that the resident was assessed as requiring feeding in bed.

In a review of the progress notes and 24-hr report, there was no information indicating that the resident required to be fed in his/her room for breakfast on December 4th, 2015.

During an interview with the Administrator/Clinical Manager, she indicated that it was the home's expectation that residents served breakfast in bed would have been assessed and the instructions would be provided in the residents' plan of care. She further indicated that on exception, if a resident had a restless night, this information would be communicated to staff at report, a note would be entered in the progress notes and then staff would offer the resident breakfast in bed to rest. [s. 73. (1) 3.]

3. The licensee has failed to ensure that meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs.

On November 30, 2015 at 12:50 during a lunch observation, Inspector #545 observed Food attendant #128 serving a bowl of soup and a plate of food to resident #031 at once. A few minutes later, PSW #129 was observed bringing a bowl of pureed soup to resident #054 and an empty plate which she used to cover the resident's pureed potatoes, meat and vegetables that was previously served. At 13:20, PSW #113 was observed offering a chocolate cake to resident #048 while the resident was still eating his/her lunch, the cake was placed in front of the resident and the PSW removed the half eaten plate away.

During an interview with the Administrator, she indicated that staff were expected to serve all meals course by course and that it was not acceptable that residents be served their dessert while they were still eating there meal or their soup at the same time as their main course. [s. 73. (1) 8.]

4. The licensee has failed to ensure that residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance.

On December 4, 2015 from 07:55 to 09:10, Inspector #545 observed PSW #108, Volunteer #110 and Food Attendant #115 assisting residents in dining room on unit 2AB. Other PSWs were observed entering and leaving the dining room for a few minutes at a time to bring residents for breakfast, to pour milk over cold cereal, or to clear tables. The RPN was observed outside the dining room administrating medications.

At 07:55, Inspector #545 observed PSW #108 feeding resident #053 in dining room on unit 2AB. Resident #052 was sitting alone at the table with 3 beverages and a bowl of cold cereal with milk placed behind the glasses, the resident was asleep and was not provided assistance with eating until 09:10 when PSW #108 was observed feeding thicken juice to the resident with a spoon. In the resident #052's plan of care, it was indicated that staff should be sitting with him/her to encourage him/her to eat and to provide assistance when he/she was not eating.

Resident #048 was observed at 08:05 with a bowl of cold cereal set in front of him/her. The resident is sleeping with his/her head leaned forward. At 08:20, PSW #108 who was still feeding resident #053, told resident #048 that he/she was dreaming, the resident woke and ate a few spoonfuls and fell asleep again. At 09:10, the resident was observed in the dining room, with a bowl of cold cereal in front of him/her, approximately 25% eaten, the resident was sleeping. In the resident's plan of care, it was indicated that the resident frequently required assistance for eating.

Resident #049 was observed entering the dining room at 08:10 wheeled in by PSW #113 who poured milk over the resident's cereal then left. At 08:25, the resident was sitting in front of his/her cereal food, and had not yet touched any of it. The inspector observed the resident removing a chunk of mushy cornflakes with his/her fingers and put it in the plate with his/her cut up bananas. No assistance or encouragement was provided. Twenty five minutes later, at 08:35, PSW #111 was observed standing by resident #049 and offering pieces of toasts. In the resident's plan of care, it was indicated that the resident required extensive assistance of one person with eating.

Food attendant #115 indicated to Inspector #545 that she was often alone to serve residents in the dining room and that PSWs were busy on the unit getting residents up for breakfast. She further indicated that if she did not set the tables ahead of time, she would not be done by 09:00, as residents were often arriving late for breakfast.

During an interview with the Administrator, she indicated that it was the home's expectation that staff serve food, for example breakfast to residents only when staff was

ready to provide eating assistance to the residents. [s. 73. (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 the weekly menu including breakfast is communicated to the residents, the meal service is provided in a congregate dining setting for resident #031 and #046, meals are served course by course and residents requiring assistance to eat are only provided with their meal when the assistance is available, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

Resident #002 was observed with a frog clip restraint in the wheelchair. PSW #121 indicated to Inspector #550 the resident requires a seat belt in place at all times when in his/her wheelchair because he/she forgets he/she can no longer walk and would fall.

Inspector #550 reviewed resident #002's health records and was unable to find documentation on who applied the device and the time of the application, all assessment, reassessment and monitoring, including the resident's response, every release of the device and all repositioning, and the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

The Administrator/Clinical Manager and RN #101 indicated to the inspector PSWs are responsible to document who applied the device and the time the application, the assessment, reassessment and monitoring, the resident's response, the release of the device, all repositioning and the removal of the device on the "Restraint Monitoring" sheet. The Administrator/Clinical Manager indicated they were not able to find any restraint monitoring sheets for this resident. [s. 110. (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 resident #002's response, the release/repositioning and discontinuance or removal of the device including the time is documented, to be implemented voluntarily.

WN #7: 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:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

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:

1. Falls prevention and management.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.

During an interview, the Administrator/Clinical Manager indicated to Inspector #550 the staff receive their training by completing e-modules on the computer. She indicated the completion of the training was as follows:

-training on minimizing of restraints: in 2014, 19 out of 212 direct care staff completed the e-module and so far in 2015, 27 out of 211 direct care staffs have completed it.

-training on falls prevention and management: in 2014, 19 out of 212 direct care staff completed the e-module and so far in 2015, 120 out of 211 direct care staffs have completed it.

The Administrator/Clinical Manager indicated this training is to be completed annually and one year is from January 1st to December 31st. [s. 221. (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 staff who provide direct care to residents receive annual training on falls prevention and restraints as per the requirements of the legislation, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to immediately forward any written complaint concerning the care of a resident or the operation of the long-term care home to the Director.

Between February 26, 2015 and October 23, 2015, the home received ten (10) written complaints from resident #031's Power of Attorney (POA) concerning the care of her sibling such as:
-lack of expertise from a specific PSW and requesting that the PSW no longer provide care to resident #031
-lack of care provision observed by unclean hair of resident #031
-questioning reason for urinary track infection within first week of admission
-lack of continence care
-lack of dental care
-lack of altered skin monitoring

and concerns about the operation of the home, such as:
-lack of communication
-lack of supervision on the unit
-frequent changes in seating arrangement for resident #031 in the dining room
-lack of staff in the dining room serving meals to residents
-missing money in the resident's room
-clothing not being labeled

During an interview with the Administrator/Clinical Manager #117, she indicated that the ten written complaints received by Resident #031's POA between February 26, 2015 and October 23, 2015, were not forwarded to the Director of the Ministry of Health as per legislation. [s. 22. (1)]

WN #9: 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. 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:

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.

On a specific day in September 2015 resident #056 was observed by RPN staff #127 in the dining room inappropriately touching resident #058's.

On another specific day in September 2015 resident #056 was observed by PSW #139 inappropriately touching resident #056.

Both incidents were reported to the Director on 2 separate specific dates in September 2015.

During an interview, the Administrator\Clinical Manager indicated to Inspector #592 that the home's process for reporting is that the RPN reports to the RN in charge of the unit, the RN in charge notifies the on-call nurse at St-Vincent who will call the Clinical on-call who in turn will notify the Administration and the Director. She further indicated that the first incident in September was not reported by the RPN #127 to the nurse in charge of the unit RN #104. The second incident in September was reported to RN #104 by RPN #127 when the incident occurred but the RN #104 did not notify the on-call nurse at St-Vincent as she was supposed to. Therefore the Director was notified of these incidents by the Administrator when she became aware of the two incidents on 2 separate specific dates in September 2015.

This section was issued as part of a Compliance Order for S. 19 Duty to Protect on July 27th, 2015 with a compliance date of December 1, 2015. [s. 24. (1) 2.]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care includes an order by the physician or the registered nurse in the extended class.

Resident #002 was observed by Inspector #550 in the dining room sitting in the wheelchair with a frog clip seat belt. PSW#121 indicated to the inspector during an interview that resident #002 requires a seat belt in place at all times when in the wheelchair because he/she forgets he/she can no longer walk and would fall.

Resident #002 was assessed by the Occupational Therapist on a specific date in September 2015 who suggested frog clip seat belt with slip cover. Inspector reviewed the resident's health care records and observed there were no physician or registered nurse in the extended class order for this restraint since October 2015. The Administrator and RN staff #S101 were unable to find a physician order for November or December 2015 and indicated there should be a physician order every 30 days for the restraint for resident #002 as per their home policy. [s. 31. (2) 4.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #30 was bathed, at a minimum, twice a

week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Resident #030 indicated to Inspector #545 that he/she was offered one bath per week, and could really benefit from a second bath to help sooth considerable pain he/she suffers from a specific body part.

Upon review of the resident's health record, it was documented that Resident #030 required assistance of one person for bathing but 2 persons for transfers into the tub. The bath list indicated that the resident was scheduled for a bath on 2 specific days of the week.

The Daily Flow sheet was reviewed for several months and the following was documented:

December 2015
-one bath received on a specific date
-bath refused on a specific date

November and October 2015
The home was unable to provide Daily Flow sheets and demonstrate documentation of bathing

September 2015
-bath received on 5 specific dates, therefore received 5 out of 9 possible baths

August 2015
-no baths documented
-tub bath refused once

July 2015
-tub bath received once, therefore received 1 out of 9 possible baths

During an interview with PSW #113 and PSW #111 they indicated that the resident was scheduled to receive a tub bath 2 days per week, and that bathing received or refused was documented in the Daily Flow sheets kept in the chart room. They both indicated that the resident required assistance of one person for bathing, that the resident was able

to assist in washing his/her face and arms and required assistance for dressing. PSW #113 further indicated that the Resident was pleasant and never resisted care but on a specific day when there is a specific activity scheduled, the resident preferred to be bathed before the activity and if offered to be bathed too close to the activity, the resident might decline as did not like to feel stressed for time.

During an interview with RN #135, she indicated that bath schedules were programmed and very difficult to change, therefore if a resident declined a bath, there was little chance for this resident to be offered a bath on a different day, as most residents did not like to switch their bath days.

During an interview with the Administrator/Clinical Manager, she indicated the it was the expectation of the home that residents receive two baths per week, by the method of choice. She indicated that staff should be revising the bath schedule to meet residents' needs and preference and offer a bath on a different day if it keeps coinciding with an activity the resident enjoys. [s. 33. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #011 received mouth care in the morning and evening.

On December 1, 2015 resident #011 indicated to Inspector #547 that he/she requires assistance to brush his/her teeth and he/she only has them brushed in the evenings. The resident indicated that he/she preferred to have them brushed in the morning and evening if twice a day was an option.

PSW #103 indicated to Inspector #547 on December 3, 2015 that he was the resident's primary caregiver on days, and that he did not provide mouth care on days, as night shift staff get the resident up and dressed on night shift in the early morning. PSW #103 indicated that he has also worked nights and the resident would refuse to have his/her mouth care done and that they are supposed to indicate an "R" in the documentation to communicate this to the next shift. PSW #103 indicated that he never offered the resident mouth care on days, as he assumed night shift staff did this task.

Record review of the resident's plan of care identified that resident #011 required dental care daily. Review of the basic care flow sheets for November 2015 indicated no documentation of provision of care for day and evening shift on 4 specific dates in Nov. and no documentation of the provision of care by night staff was found for the month. [s. 34. (1) (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #031 receives fingernail care, including the cutting of fingernails.

Resident #031 has several medical conditions including paralysis of a specific limb and cognitive deficit. According to the most recent assessment, the resident was assessed as requiring total care by 2 staff for personal hygiene including nail care.

During an observation on December 1, 9 and 10, 2015, Inspector #545 observed resident #031's fingernails. The nails of both hands were untrimmed and unclean with brownish debris.

In a review of the unit's bath list, it was indicated that the Resident was scheduled for a tub bath on two specific days. In the Daily Flow Sheet for the month of December 2015, it was documented that a bath was provided to the resident on 3 specific days.

During an interview with PSW #108, she indicated that staff were expected to provide nail care on bath days. She indicated that the resident did not resist care, however displayed fear and voiced complaints of pain during care provision. She indicated that she had no difficulty with providing nail care to the resident.

PSW #134 indicated that she was expected to provide nail care during morning care and on bath days. She indicated that she had provided morning care with another PSW this morning to Resident #031, but had not provided nail care, as she had not noticed the nails.

RN #135 indicated that nail care should be provided as part of daily care, at least once per week. After verifying the Resident's nails she indicated that the nails had not been trimmed and would ensure nail care would be provided. [s. 35. (2)]

WN #14: 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 has failed to ensure that when resident #011 fell on five occasions between two specific months in 2015, that the resident did not have any post fall assessment conducted for four of the five falls using a clinically appropriate assessment instrument designed for falls.

On December 2, 2015 RPN #106 indicated to Inspector #547 that Resident #011 was assessed on a specific date in November 2014 to be high risk of falls and has just been changed to need two person assistance for transfers as a result of his frequency of falls in the last 30 days. RPN #106 indicated that after any resident has a fall, they are to complete an incident report on their Reporting Incident Management System (RIMS).

Administrator/Clinical Manager #117 reviewed the RIMS for Resident #011 for the period of two specific months in 2015 and indicated that only one out of five falls were tracked for this resident that should have been completed for every fall. [s. 49. (2)]

WN #15: 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity receive a skin assessment by a member of the registered nursing staff upon any return from hospital.

Resident #031 had multiple medical conditions. As per the most recent assessment, the resident's scored 5 out of 8 on the Pressure Ulcer Risk Scale (PURS) which indicates a higher relative risk for developing a pressure ulcer. The assessment also indicated that the resident required total care for bed mobility, transfers and was wheelchair bound.

During an interview with the Nurse Practionner #136, she indicated that the resident was at risk of altered skin integrity, required repositioning every 2 hours, and was prescribed a special mattress as strategies to prevent pressure ulcers due to immobility.

In the most recent plan of care it was documented under Nutrition that the resident was provided extra protein three times daily to meet requirements for wound healing.

In a review of resident #031's health record, it was indicated that the resident was admitted to the hospital twice in a specific period of time.

There was no evidence to indicate that a skin assessment was conducted upon return from hospital.

The most recent Skin Assessments indicated that the resident had a pressure ulcer at a stpecific stage on a specific body part. An hydrophilic cream was prescribed, and on a specific date in December 2015 to indicate that the wound was healed.

During an interview with RN #135, she indicated that it was the home's expectation that a skin assessment be conducted upon return from hospital, and documented in the resident's progress notes. She indicated that Resident #031 was at risk of altered skin integrity, had a history of pressure ulcers. The RN was unable to provide evidence of completed skin assessments between two specific months in 2015.

During an interview with the Administrator/Clinical Manager, she indicated that it was the expectations of the registered staff to conduct a skin assessment for residents upon return from hospital, and further added that resident #031, at risk for altered skin integrity should have had a skin assessment on a specific date in 2 specific months and on another specific date in another specific month in 2015 when returned from two different hospital admission. [s. 50. (2) (a) (ii)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that concerns or recommendations made by the Family Council in writing are responded within 10 days.

The President of Family Council indicated to Inspector #547 on December 8, 2015 that she has sent an electronic message to the Executive Director (ED) on October 25, 2015 regarding a concern a family member asked of Family Council and requested recommendations from the ED regarding use of personal video cameras in residents rooms process in the home to assist this family. The President of Family Council has not received any response to the request to date.

The ED indicated to Inspector #547 during an interview on December 9, 2015 that he recalled this request however he could not recall if any response was returned in writing to the Family Council.

The President of Family Council further indicated another electronic message sent to the home's Administrator on November 20, 2015 regarding specific concerns and observations made by members of the Family Council that she has not received any response to date.

Inspector #547 interviewed the Administrator on December 9, 2015 and confirmed that she had not responded to the Family Council request for meeting regarding several concerns and observations made by the Family Council. [s. 60. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home are labeled properly and are kept inaccessible to residents at all times.

On November 30, 2015, Inspector #550 observed the cupboard door under the sink in the servery on the first floor secured unit was unlocked during lunchtime. The servery is located within the dining room where many residents were having their lunch at that time and others were wandering. Inside the cupboard there was a spray bottle of ''Oasis multi-quat sanitizer'' from Ecolab and the label on the bottle indicated ''do not drink''. There was also a bottle of ''Total universal cleaner and polish'' and the label indicated ''toxic''.

On December 1, 2015, the inspector observed the accordion door to the servery was closed with the key in the lock. Inside the servery, the cupboard door under the sink was still unlocked.

During an interview, the Director of Care staff #116 indicated to Inspector #550 the cupboard door must be locked at all times. The accordion door to the servery must be locked when not in use and the key must be kept hung inside the report room (with the red emergency bag). [s. 91.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of alleged financial abuse of resident # 015.

The Ministry of Health and Long Term Care "Abuse Decision Tree Guide" dated May 2012 indicates under financial abuse that theft may be considered a criminal offense under the criminal code s.322 C. C.

During the winter of 2015, resident #015 was admitted to the home. Three days later, resident #015 realized that his/her wallet which had fifty dollars in it was no longer in his/her room. Resident # 015 and his/her cousin notified Registered Nurse #131 who notified the Clinical Manager that same day.

On December 7, 2015, Inspector #126 interviewed the Administrator/Clinical Manager #117. She indicated that she met with resident #015 and that the interview/investigation was inconclusive because there was some discrepancy in the information provided by the resident and the nurse.

On December 7, 2015, the Administrator/Clinical Manager #117 indicated to Inspector # 126 that the police was not notified of the incident of theft. [s. 98.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 100. Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.

Findings/Faits saillants :

1. The licensee has failed to ensure that there is written complaint procedures in place that incorporate the requirements set out in section 101 for dealing with complaints.

Complaints and Concerns from Patients and Family, policy number ADMIN 02 (revised June 2015) was provided to the Inspector by the Administrator/Clinical Manager upon request for the home's complaints policy.

A review of the Complaints policy demonstrated that the policy did not incorporate the

following requirements set out in section 101 for dealing with complaints:

The complaint procedure did not indicate, as defined by O. Reg 79/10 s. 101 (1), that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief, as defined by O. Reg. 79/10, s. 101 (1).

The Complaint procedure did not indicate, as defined by O. Reg 79/10 s. 101(2), that a documented record is kept in the home that includes,
(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

During an interview with the Administrator/Clinical Manager, she indicated that she was not familiar with the home's Complaints policy, that she had not reviewed it before this week. After reviewing the policy, she indicated that the policy would be reviewed to ensure that it incorporated all the requirements as per legislation. [s. 100.]

WN #20: 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. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation commenced immediately.

During 9 specific months in 2015, the home received ten (10) written complaints from Resident #031's Power of Attorney (POA) concerning the care of this resident such as:
-lack of expertise from a specific PSW and requesting that the PSW no longer provide care to Resident #031

-lack of care provision observed by unclean hair of Resident #031
-questioning reason for urinary track infection within first week of admission
-lack of continence care
-lack of dental care
-lack of altered skin integrity

and concerns about the operation of the home, such as:
-lack of communication
-lack of supervision on the unit
-frequent changes in seating arrangement for Resident #031 in the dining room
-lack of staff in the dining room serving meals to residents
-missing money in the resident's room
-clothing not being labeled

During an interview with the Administrator/Clinical Manager #117 she indicated that she was not aware that an investigation was required immediately where the complaint alleged harm or risk of harm to one or more residents. She indicated that she received many emails from resident #031's POA, and that usually contacted the complainant by phone, or in person and that an investigation was conducted, but not always immediately after receiving the complaint. She further indicated that she did not document her investigation, therefore was unable to demonstrate evidence of completed investigation for the ten (10) written complaints received by resident #031's POA. [s. 101. (1) 1.]

2. The licensee has failed to ensure that 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

During 9 specific months in 2015, the home received ten (10) written complaints as described above.

During an interview with the Executive Director, he indicated that it was the responsibility

of the Executive Director, the Administrator, the Clinical Managers to enter complaint information into the Complaints Tracking Sheet. He further indicated that the Administrative Assistants also access the Complaints Tracking Sheet.

The home's Complaints Tracking Sheet was reviewed by Inspector #545. The electronic spreadsheet was set up with several columns, such as:
-Date Complaint Received
-Name of Service / Unit involved
-How was the complaint logged (phone, writing, person)
-Complaint received by Summary of Complaint
-Follow-up done by and date
-Complainant's name
-Complainant's contact Information
-Complainant's relationship to patient
-Complaint Status Active or Closed
-Documentation (attached documents)

Out of the ten (10) written complaints received by resident #031's POA, one complaint was recorded in the tracking sheet. The nine (9) other written complaints could not be found.

During an interview with the Administrator/Clinical Manager, she provided Inspector #545 with a LTC Complaint Tracking Form that she designed to facilitate the recording of verbal, email, written and phone complaints. She indicated that letters and documentation were attached to the completed form and given to the Administrative Assistants to enter in the electronic Complaints Tracking Sheet. The Administrator/Clinical Manager further indicated that the 9/10 written complaints received by resident #031's POA had not been recorded in the Complaints Tracking Sheet, therefore she was unable to provide evidence of documented record for nine out of 10 written complaints. [s. 101. (2)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. 1.The licensee has failed to ensure that the report to the Director included the following analysis and follow-up actions:
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence

A Critical Incident Report was submitted to the Director on a specific date in 2015 indicating that resident #055 had reported an incident of sexual abuse by a staff member. The Critical Incident Report did not indicate the long-term actions planned to correct the situation and prevent recurrence.

It was then requested by the Centralized Intake Assessment and Triage Team to amend the Critical Incident report to include outcome of home's and Police investigation once completed.

On December 10, 2015, during a follow-up of the incident report with the home, Inspector #592 noted that the home had not informed the Director of the long-term actions planned to correct the situation and prevent recurrence as it was still written under Analysis and follow-up "to be determined" as it was previously requested.

On December 10, 2015, in an interview with the Administrator/Clinical Manager, she told Inspector #592 that the home's internal investigation was concluded on a specific date in the summer of 2015 and she indicated that she does not know why the long term actions and outcome of the home were not provided to the Director.

A Critical Incident Report was submitted to the Director on a specific date in the summer

of 2015 indicating Resident to Resident sexual abuse. The home did not at the time provided to the Director with the long-term actions planned to correct the situation and prevent recurrence.

Following the submission of the report, the home was requested by the Centralized Intake Assessment and Triage Team to amend the critical Incident report to include inquiring if the resident had any history of similar incident and to include new intervention in place to prevent recurrence.

On December 11, 2015, during a follow-up of the incident report with the home, inspector #592 noted that the home had not informed the Director of the long-term actions planned to correct the situation and prevent recurrence as it was still written under Analysis and follow-up "unsure at this point".

On December 11, 2015, in an interview with the Administrator/Clinical Manager, she told inspector #592 that the home did not keep track of the request , therefore, she indicated that she does not know why the long term actions and outcome of the home were not provided to the director. [s. 104. (1) 4.]

WN #22: 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):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

Resident #002 fell on a specific date in the summer of 2015 and was transferred to the hospital with a fractured body part. During an interview, the Administrator/Clinical Manager indicated to Inspector #550 the critical incident report was not submitted to the Director.

As such, The Director was not informed of this incident that resulted in a significant change in the resident's condition. [s. 107. (3) 4.]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with, (b) duties and responsibilities of staff, including, (i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device.

Inspector #550 was provided with and reviewed the home's policy on restraints titled "Restraint Minimization", last revision date 2013-11.

Inspector observed the policy does not address the duties and responsibilities of staff including who has the authority to apply a physical device to restrain a resident or release a resident from a physical device, ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device.

During an interview, the Administrator/Clinical Manager confirmed to Inspector #550 that this requirement of the legislation was missing in their policy. [s. 109. (b)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that, (c) there is, at least quarterly, a documented

reassessment of each resident's drug regime.

Resident #017 was admitted to the home in the fall of 2015, with multiple diagnoses and a fracture of a specific body part which occurred earlier in 2015. According to the admission assessment, the resident indicated he/she had no pain.

During an interview, the Resident indicated to Inspector #545 that he/she could not understand why the nurses were insisting on giving him/her 2 specific pain pills as the resident had no pain and did not want any. The resident further indicated that one nurse, had tried to put the 2 pain pills in his/her mouth and he/she refused to take them.

Upon review of the Resident's plan of care, there was no information indicating that Resident #017 had pain and that an analgesic was required for pain management.

In a review of the Resident's health record, a physician order dated in the fall of 2015, indicated that Resident #017 was prescribed an analgesic four times daily (QID), to be administered as needed. The Pharmacist recommended that a reason for administration of the analgesic be included. It was later documented in the physician's order that the specific analgesic was to be administered three times per day (TID), along with a referral to a physiotherapy for the old fracture. Later, the physician decreased the analgesic to once a day at bedtime.

In a review of the Resident's progress notes, it was documented on 2 specific dates in 2015 that the resident refused the analgesic indicating he/she had no pain. On another specific date in 2015 the physiotherapist assessed the resident who indicated that the resident had mild to moderate intermittent pain to a specific body part but that the resident did not want pain medication as stated that the pain did not last long. On that that same day, a note from a registered staff indicated that the resident refused the analgesic but the prescription would be continued due to occasional pain. On a specific date the physician decreased the analgesic fom TID to once daily at bedtime. The following day, a note indicated that the resident refused the analgesic every evening for 24 days in a specified month in 2015.

The Medication Administration Record was reviewed, which indicated that Resident #017 refused the analgesic 33 times out of 42 times in two specific months in 2015 when nurses offered the medication TID, and he/she refused 26 out of 29 times for two other specific months in 2015, when the analgesic was offered at bedtime.

During an interview with RPN#100, she indicated that she did not know why the analgesic was prescribed, she further indicated that the Resident refused the medication when offered, stating he/she had no pain. The RPN indicated that the Resident would remove a specific medication from the medication cup, then pass the cup back to the nurse indicating he/she did not want the analgesic, adding it makes him/her sleepy and the resident did not want that.

RPN #107 indicated to the Inspector that when the medication was first prescribed, she remembers explaining to the resident that the analgesic was prescribed by the physician for pain, added that she did insist but when the resident hit the medication cup down and stated loudly that he/she would not take it as he/she had no pain, she stopped insisting. The RPN further indicated that the analgesic was discontinued on the day shift, shortly after.

RN #101 indicated that the specific analgesic was prescribed because the resident was admitted with a fracture and was elderly. The RN indicated she was aware that the resident refused the analgesic, that it had been decreased from TID to once daily at bedtime. She indicate that she would be contacting the physician to suggest that the medication be offered as needed, as the resident had no need for regular pain medication and he/she did not want it.

The DOC #116 indicated to the Inspector that the registered staff are expected to consult with the physician when residents repeatedly refuses a medication. The DOC further indicated that in the case of resident #017 who consistently refused the analgesic every evening from November to December 2015, the physician should have been notified and informed that the resident denied pain and did not want administration of analgesic.

As such, there was no quarterly documentation of the reassessment of resident #017's drug regime. [s. 134. (c)]

WN #25: 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. (2) The drug destruction and disposal policy must also provide for the following:
1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's drug destruction and disposal policy provides for drugs that are to be destroyed and disposed of, shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

On December 3, 2015 RPN#100 indicated to the Inspector that resident #017 refused a specific analgesic on three separate days in two specific months in 2015 in the evening. She added that he/she kept the refused tablets of the analgesic in the locked medication cart, then showed the inspector three opened individual packages which were labeled with resident #017's name, room number, name and dosage of medication and date of administration. Two of the packages contained one tablet of the specific analgesic and one package contained two tablets, the RPN indicated that the missing tablets had fallen at the bottom of resident #017's medication bin (top drawer of Medication Cart), and pulled them out. She indicated to the inspector that she had not yet destroyed the refused analgesic as she wanted to prove that the Resident had not taken them. The RPN then, placed all three opened individual packages with the specific analgesic, 2 tablets, into the 4th drawer of the medication cart, in a small plastic basket under a box of Vitamin D injectable.

During an interview with RN#101, she indicated that it was the home's expectation that registered staff destroyed all refused medications in the locked drug destruction box in the locked Medication Room. Along with RPN #100, they destroyed the three individual packages of the specific anlagesic that had been refused by resident #017 on three separate days in two specific months in 2015.

The Clinical Manager #116 indicated to Inspector #545 that it was the home's practice and expectation that registered staff disposed of refused medications, directly into the sharps container available on the Medication Cart or into the locked Medication Destruction box located into the locked Medication Room. She then reviewed with the Inspector the home's Medication Destruction Policy, titled: "Contrôle des stocks - Élimination des médicaments", Index Number: 02-06-20, revised October 1, 2012 and indicated that the policy did not provide for drugs that are to be destroyed and disposed of, shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs. [s. 136. (2) 1.]

Issued on this 22nd day of January, 2016

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

Original report signed by the inspector.