Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 23, 2014	2014_179103_0006	O-000230-14	Resident Quality Inspection

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9

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

ROSEBRIDGE MANOR
131 Roses Bridge Road, R. R. #2, Jasper, ON, K0G-1G0

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

DARLENE MURPHY (103), MEGAN MACPHAIL (551), RENA BOWEN (549)

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): April 7-11, 14-17, 22, 2014

2 complaints (Log #'s: O-000016-14 and O-000143-14) and 1 Critical incident (Log #:O-000190-14) were included as a part of this inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, President of Resident Council, President of Family Council, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support workers (PSW), Dietary aides, Nutritional Care Manager, Dietitian (RD), Physiotherapist, Housekeeping staff, Environmental Service Manager, Life Enrichment Coordinator, RAI Coordinator, Nursing Administrative Services Manager, Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector(s) completed a walk through tour of all resident areas, observed medication storage areas, reviewed resident health care records, observed resident care, resident dining, and medication administration, reviewed relevant home policies and infection control practices, reviewed the home staffing schedules and staffing plan.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 3 (1) 8. whereby resident rights to be afforded privacy in treatment and in caring for his or her personal needs were not protected.

During the observation of medication passes, the inspector observed S#110 and S#125 doing glucometer checks on several residents and administering insulin injections at the breakfast table while both the residents and the co-residents were eating their breakfast.

The Director of Care was interviewed and stated this is not considered an acceptable practice in the home. [s. 3. (1) 8.]

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 residents have glucometer checks and insulin injections given in a private area, 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 6 (7) whereby the care set out in the plan of care was not provided to the resident as specified in the plan.

Resident #9656's plan of care for falls and balance was reviewed. The resident has been assessed as a high risk for falls. Under "Interventions" the care plan indicated, call bell with in reach when in bed and encourage resident to ring for assistance to prevent falls. On identified dates, the resident was observed seated in a wheelchair at the end of the bed and the call bell was attached to the bedrail at the head of the bed out of the resident's reach.

Resident #9654's plan of care for falls and balance was reviewed. The resident has been assessed as a high risk for falls. Under "Interventions" the care plan indicated, call bell with in reach when in bed to prevent falls. On identified dates, the resident was observed in bed with the call bell on the bedside table out of the resident's reach.

Resident #9669's plan of care for falls and balance was reviewed. The resident has been assessed as a high risk for falls. Under "Interventions" the care plan indicated, encourage client to ask for assistance with use of call bell and ensure the call bell is within reach at all times. On identified dates, the resident was observed sitting in the wheelchair at the side of the bed with the call bell tied to the bedrail at the top of the bed, hanging at floor level out of the resident's reach.

Resident #9688's plan of care for falls and balance was reviewed. The resident has been assessed as a high risk for falls. Under "Interventions" the care plan indicated, place common items within reach at all times example, call bell, comb and telephone. On identified dates, the resident was observed in bed with the call bell attached to the bedrail at the head of the bed, hanging at floor level out of the resident's reach.

Resident #9713's plan of care for falls and balance was reviewed. The resident has been assessed as a risk for falls. Under "Interventions" the care plan indicated, encourage client to ask for assistance with use of the call bell and ensure the call bell is within reach at all times. On identified dates, the resident was observed in bed with the call bell attached to the bedrail at the head of the bed, hanging at floor level out of the resident's reach.

Resident #9720's plan of care for falls and balance was reviewed. The resident has been assessed as a risk for falls. Under "Interventions" the care plan indicated, place common items within reach at all times example, call bell, comb and telephone. On identified dates, the resident was observed in bed, positioned on his/her left side with the call bell attached to the right bedrail at the head of the bed, hanging at floor level out of the resident's reach. [s. 6. (7)]

2. Resident #9697's plan of care indicates diet as "pureed texture with nectar thick fluids". Resident #11's plan of care states diet as "pureed texture, nectar thick fluids". S#112, S#127 and S#128 were interviewed and stated that foods that melt in the mouth and become thin liquids are given to residents who are ordered thickened liquids.
On an identified date, Resident #9697 was given sherbet at lunch. The Therapeutic

Spreadsheet stated that residents on thickened liquids should have received raspberry mousse. On another identified date, Resident #11 was given ice cream at lunch. The Therapeutic Spreadsheet stated that residents on thickened liquids should have received chocolate mousse. [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 fall prevention measures are in place in accordance with plan of care and residents receive their diet textures as ordered, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Regs. 79/10 s. 8 (1) whereby the policies required under O. Regs. 79/10 s. 114 (2) to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used at the home were not complied with.

During the observation of a medication pass, S#125 was observed signing on the resident Medication Administration Record (MAR) prior to the administration of the medications to each resident.

The home policy, "The Medication Pass", #3-6, under Procedure, states administer medications and ensure they are taken, document on MAR in the proper space for

each medication administered or document by code if medication is not given.

The licensee has failed to comply with O. Regs. 79/10 s. 8 (1) whereby the policies required under O. Regs. 136 (1) (a) for the management of expired drugs was not complied with.

During the observation of the medication storage area, two expired bottles of Bronchophan cough syrup were found. One bottle had an expiry date of May 2013 and other had an expiry date of January 2014.

The home policy, "Medication Storage", #3-4, under Procedure states, monitor expiry dates on a regular basis (monthly).

The licensee has failed to comply with O. Regs. 79/10 s. 8 (1) whereby the policies required under O. Regs. 136 (2) 2. for drug destruction of controlled substances was not complied with.

S#110 and S#125 were interviewed in regards to the process of destroying a controlled medication when prepared for administration and then refused by a resident. S#125 stated the medication would be witnessed by a second registered staff member and then discarded into the sharps container that is located in the bottom drawer of the medication cart.

The Director of Care (DOC) was interviewed and confirmed this would not be considered an acceptable means of destroying a controlled substance. The DOC demonstrated the area where the controlled drugs for disposal are discarded and stated she is the only one that has keyed access. The locked box was opened by the DOC and a card of discarded narcotics was reviewed. The narcotic card had the drug destruction form attached to it which indicated the amount of medication to be destroyed and was double signed by two registered staff. A single narcotic medication was observed in the locked box with no attached documentation. The DOC confirmed this medication was placed into the locked box without the appropriate documentation.

The home policy, "Drug Destruction and Disposal", #5-4, under Procedure for monitored medications states, two nurses record the quantity for destruction, initials, date and reason for destruction at the bottom of the form, attach the form to the balance of the medication to allow verification of the amount to be destroyed, both

nurses complete and double sign Drug Destruction and Disposal form and place the medication into a locked monitored drug storage until drug destruction takes place.

The licensee has failed to comply with O. Regs. 79/10 s. 8 (1) whereby the policies required under O. Regs. 136 (3) (b) for the destruction of non-controlled drugs was not complied with.

S#124 and S#113 were interviewed and asked to describe the home's process on the destruction of non-controlled medications. Both indicated the medications are placed into a Stericycle bin that is located in the locked medication room. The Stericycle bin was located in the main medication storage area next to the medication administration carts. The inspector observed many resident medication strip packs and cards of medications in the half filled Stericycle box. The medications had no evidence of being altered to discourage consumption. Both staff indicated a registered staff member would place the discarded medications into the bins and when it is filled, it is sealed and moved to a locked room on the back hallway of the home to await pick up by the disposal company. Both staff stated nursing staff discard the medications independently and it is not necessary to have a second staff member witness the disposal/destruction. Additionally, both staff members stated there is no paperwork completed for the disposal of non-controlled medications.

The DOC was interviewed, confirmed the above information and stated there are no log records of the destroyed non-controlled medications..

The home policy, "Drug Destruction and Disposal", #5-4 under procedure for non-monitored medications indicates, medications for destruction are removed from all medication storage areas and retained in a secure area in the medication room, separate from medications for administration to a resident, until such time as they are transferred to the designated Stericycle box/container for destruction and disposal. On a routine basis (monthly at minimum), medications for destruction are transferred from the separate storage area to the Stericycle box by the team of a nurse and another staff member and documentation of the date and the unit the medications are from are signed off in a log book by both team members. Destroy medications so that their consumption is rendered impossible or improbable. [s. 8. (1)]

2. The licensee has failed to comply with O. Regs. 79/10 s. 8 (1) whereby the policies required under O. Regs. 79/10 s. 68 (2) (a) were not complied with.

Resident #9720's care plan was reviewed and has been assessed as a high nutritional risk related to a "low weight, variable intake, and very poor glycemic control"

The food and fluid intake monitoring sheets for April 1 to 14, 2014 were reviewed and the resident's intake of food and fluids was not documented six out of fourteen times at breakfast, seven out of fourteen times at lunch, zero out of thirteen times at supper and one out of thirteen times at bedtime snack pass.

The home policy, "Food and Fluid Intake", NC-1.8, under Purpose states, monitor the food, fluid and supplement intake of each resident at meal and nourishment times, and under Policy states, nursing and personal care staff shall be responsible for monitoring and recording intake subsequent to each meal and nourishment pass. Under Procedure states, after the resident has completed his/her meal, but before dishes are cleared, the HCA/PSW shall note the amount of food consumed by the resident on their assignment sheet. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all policies related to medication administration, medication storage, removal of expired drugs, drug destruction of both controlled and non-controlled substances and the monitoring of food and fluid intakes are complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Regs. 79/10 s.16 in that the licensee has not ensured that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimeters.

Inspector #549 examined the windows in the south end resident TV room/ lounge, "The Rose Garden Room". There are four windows in this resident area which open inwards. Two of these windows have chains connected to them can be opened to 20 centimeters. The two remaining windows in this resident area do not have chains connected to them and can be opened to 35 centimeters.

In the East corridor, there are three resident rooms that have upgraded aluminum slider windows which have an opening of 15 centimeters or less. In the same corridor, there are approximately thirteen windows in resident rooms that are of the older style slider windows. Metal stoppers are screwed to the windows on top and bottom to prevent the window from sliding all the way open. In resident room #36 the window can be opened to 19 centimeters and in resident room #40, the window can be opened to 17 centimeters.

As Inspector #549 was attempting to measure the opening of one of these windows, the window pane itself came off the sliding track and out of the window frame. Inspector #549 was holding the entire window pane. There was little to no effort made on the part of Inspector #549 to remove the window. Inspector #103 was also able to remove the sliding window panes in resident room #32 with little effort. [s. 16.]

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 all windows in the home are audited and repaired to prevent them from opening greater than 15 centimeters, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Regs. 79/10 s. 17 (1) (a) whereby the resident-staff communication and response system was not accessible to residents at all times.

Resident #9654 was observed to be lying in bed on two identified dates. The resident call bell was on the resident bedside table out of the reach of the resident

Resident #9656 was observed on two identified dates to be seated in his/her wheelchair at the foot of the bed. The resident call bell was observed to be attached to the bedrail at the head of the bed out of the resident's reach.

Resident #9667 was observed on three identified dates to be seated in the wheelchair at the foot of the bed. The resident call bell was observed to be on the far side of the bed out of the resident's reach.

Resident #9669 was observed on two identified dates to be seated in the wheelchair at the foot of the bed. The resident call bell was observed to be tied to the bedrail, hanging at floor level at the head of the bed out of the resident's reach.

Resident #9688 was observed to be lying in bed on two identified dates. The resident call bell was attached to the bedrail at the head of the bed, hanging at floor level out of

the reach of the resident.

Resident #9713 was observed to be lying in bed on two identified dates. The resident call bell was attached to the bedrail at the head of the bed, hanging at floor level out of the reach of the resident.

Resident #9720 was observed on two identified dates to be in bed, positioned on the left side. The resident call bell was observed to be attached to the right bedrail at the head of the bed, hanging at floor level out of the resident's reach.

Resident #2 was observed on an identified date to be positioned on the right side in bed. The resident asked the inspector to retrieve a staff member to assist with repositioning as his/her back was painful. The resident call bell was observed attached to the left bedrail out of the resident's reach. The resident stated he/she could not reach his/her call bell and staff never leave it for him/her.

Resident #4 was observed on an identified date to be seated in the wheelchair at the side of the bed. The resident call bell was not visible and found under the sheets and pillow out of the resident reach. According to the resident, it is often not left within reach. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the resident-staff communication and response system can be easily seen, accessed and used by residents at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Regs. 79/10 s. 44 whereby residents did not have equipment readily available to meeting their nursing and personal care needs.

Throughout the inspection period, Resident #9669 was observed to be seated in a wheelchair that had no foot pedals. The resident's legs were observed to be dangling without support when the chair was in the upright or tilted position. The resident reported to the inspector that he/she was not in a comfortable position.

Throughout the inspection period, Resident #9667 was observed to be improperly positioned in the transfer chair he/she was utilizing. The resident was often found with his/her head leaning forward and resting on the arm rest of the chair. When asked, the resident stated he/she was not comfortable in the chair.

S#121 was interviewed and stated both residents were in facility owned chairs and stated neither had received a seating assessment to facilitate their comfort.

Physiotherapist S#114 confirmed the same information and stated an assessment had not been completed to address either of the resident's issues related to positioning. He also stated Resident #9667 had a Public Guardian and Trustee (PGT) for finances and believed the resident had no money to purchase a suitable wheelchair although the PGT had not been consulted to date. [s. 44.]

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 all residents have equipment available to ensure comfortable positioning, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 45. 24-hour nursing care — exceptions

Specifically failed to comply with the following:

2. For homes with a licensed bed capacity of more than 64 beds and fewer than 129 beds,
i. in the case of a planned or extended leave of absence of an employee of the licensee who is a registered nurse and a member of the regular nursing staff, a registered nurse who works at the home pursuant to a contract or agreement with the licensee and who is a member of the regular nursing staff may be used,
ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met, a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if,
A. the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, and
B. a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home. O. Reg. 79/10, s. 45 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Regs. 79/10 s. 45 (1) (2) whereby the exceptions to twenty-four hour nursing care that are applicable to the home's number of licensed beds were not complied with.

Rosebridge Manor has a licensed bed capacity of 78. The following exceptions to the requirement that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, as required under subsection 8 (3) of the Act for homes with a licensed bed capacity of more than 64 beds and fewer than 129 beds are as follows:

i. in the case of a planned or extended leave of absence of an employee of the licensee who is a registered nurse and a member of the regular nursing staff, a registered nurse who works at the home pursuant to a contract or agreement with the licensee and who is a member of the regular nursing staff may be used,

ii. in the case of an emergency where the back-up plan fails to ensure that the requirements under subsection 8 (3) of the Act is met, a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an

employment agency or other third party may be used if,

A. the Director of Care and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regualr nursing staff is available by telephone, and

B. a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home.

An emergency is defined in the legislation as an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long term care home.

Registered staffing schedules were reviewed from December 2, 2013 to March 23, 2014. Registered nurses employed by an agency were utilized in the home on the following dates/shifts:

December 23 (nights), 25 (nights), 27 (evenings), 30 (evenings and nights),
January 29 (nights),
February 18 (evenings), 21 (nights), 26 (nights),
March 1 (nights), 2 (nights), 3 (nights), 4 (nights), 5 (nights), 8 (nights), 9 (nights), 10 (nights), 15 (nights), 21 (nights).

December 23, 27, 30, January 29, February 21, 26, March 8, 9, 15 and 21 were pre-booked shifts for vacancies and do not meet the definitions of allowable exceptions.

December 25, February 18, March 4, 5, and 10 were the result of requested shift changes by regular nursing staff that resulted in the shifts requiring coverage by agency staff that do not meet the definitions of allowable exceptions.

March 1,2, and 3 were the result of sick calls that did not meet the allowable exceptions.

In a interview with the Administrator, she stated the home has difficulty hiring registered nurses related to their remote location and are utilizing numerous strategies to entice the hiring of registered nurses. These include the following:

-advertising in local papers, OMNI website, Monster.Ca, Workopolis. Ca,
-word of mouth through local contacts

-referral bonus
-letters to nursing schools
-new graduate initiatives
-hiring of third year nursing students during summer months
-sharing of staff betwen OMNI homes
-Trillium HR recruitment and
-internal postings. [s. 45. (1) 2. ii. 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 the exceptions to twenty-four hour nursing care are utilized as outlined in the regulations, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Regs. 79/10 s. 14 in that the licensee has not ensured that in each resident shower there is one grab bar located on the same wall as the faucet.

There is one resident shower room on the East corridor with two showers stalls. Neither shower stall has a grab bar located on the same wall as the faucet.

There is also one resident tub room with a whirlpool tub and a shower stall in the East corridor. The shower stall does not have a grab bar located on the same wall as the faucet. [s. 14.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 15 (2) (a) whereby resident equipment is not kept clean and sanitary.

During the inspection period, the following resident equipment was found in an unclean condition:

-Resident #9699's wheelchair had white spills noted over the seat cushions and the wheels were heavily soiled with food-like material,
-Resident #9656's seat belt and seat cushion was soiled with food-like material,
-Resident #1's wheelchair frame, seat cover and lapbelt was heavily soiled with food-like material,
-Resident #9720's wheelchair was observed to be soiled with food-like material,
-Resident #9660's walker seat was observed to be covered in food-like debris and a thick layer of dust was observed on the grips,
-Resident #9708 was observed to be seated in a wheelchair with large areas of food debris noted on the foot rests
-Resident #2 was observed in a wheelchair with food debris noted on the right wheel and white food-like spills on the support behind the resident's legs

In an interview with S#116, she stated the home has a process for the cleaning of resident equipment on a weekly basis. The equipment cleaning book was reviewed for January 2014 to the date of the inspection. Resident's #9720 and #1 had no record of resident equipment cleaning during this time frame. The last documented cleaning was completed on March 21, 2014. [s. 15. (2) (a)]

2. The licensee has failed to comply with LTCHA, 2007 s. 15 (2) (c) whereby resident equipment is not maintained in a good state of repair.

Throughout the inspection period, the following resident equipment was found to be in disrepair:

-Resident #9 was observed to be seated in a wheelchair with both armrests that were cracked and had underlying foam exposed,
-Resident #3 was observed seated in a wheelchair with the right armrest noted to be cracked and had underlying foam exposed,
-Resident #9671 was seated in a wheelchair with the left armrest noted to have a missing section of padding with areas of exposed foam lifting; the right arm rest was also observed to be cracked and rough. [s. 15. (2) (c)]

WN #10: 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 comply with O. Regs. 79/10 s. 37 (1) (a) whereby resident personal items are not labelled within 48 hours of admission and of acquiring, in the case of new items.

Throughout the inspection, the following unlabelled items were observed:

-two unlabelled, used hairbrushes were found in the North tub room,
-two unlabelled toothbrushes were found on the bathroom counter in the shared bathroom for two identified rooms,
-one disposable razor and three electric razors were found unlabelled in bathroom of an identified room. [s. 37. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Regs. 79/10, s. 69 in that the licensee did not ensure that residents with significant weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.

The Registered Dietitian (RD) was interviewed and stated that a monthly report that identifies weight changes of 5% or more over a one month period, 7.5% or more over a three month period, 10% or more over a six month period and 15% or more over twelve month period is generated, and that she follows up on each of the identified weight changes.

Resident #9712's weight declined 5.1% (3.6kg) over one identified month. His/Her weight further declined 4.3% (2.9kg) over the next identified month. Overall his/her weight had declined 9.9% over three months, 21.2% over six months and 24.9% in the past year.

Resident #9712's progress notes were reviewed. For one identified month, there was no entry by any staff member addressing the significant weight loss. The RD reviewed Resident #9712's chart and confirmed that there was no progress note entry.

Resident #9712's weight had declined 8.9% (6.2kg) over a three month period before a supplement was added. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #12: 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. (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 comply with O. Regs. 79/10, s. 73. (2) (b) whereby residents who require assistance with eating or drinking are not served a meal until someone is available to provide the required assistance.

Resident #9697's plan of care for eating states one person physical assistance. Resident #9697 was observed on three identified days, and did not attempt to feed himself/herself.

On an identified date, at lunch, Resident #9697's entree was placed in front of him/her at 12:12. At 12:17, he/she was given a bite of food from S#111 who was passing beverages. Resident #9697 was fed from a standing position. At 12:21, S#111 sat and fed the resident. The entree had been placed in front of Resident #9697 nine minutes earlier. [s. 73. (2) (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Regs. 79/10 s. 129 (1) (a) whereby drugs not in use were not properly stored.

During the observation of a medication pass, S#125 removed a bottle of Lactulose labelled with Resident #9711 and a stock bottle of milk of magnesia from the locked medication cart and placed the bottles on the top of the cart. The medication nurse left these drugs unattended on four occasions while administering medications to residents seated in the dining room. At this time, several residents were seated in the circle area in close proximity to the medication cart. [s. 129. (1) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Regs. 79/10 s. 130 whereby all areas where drugs are stored are not restricted to persons who may dispense, prescribe or administer drugs in the home and the Administrator.

During an interview with S#113, she indicated non-controlled medications, that are awaiting pick up by Stericycle, are stored in a double locked room on the back hallway. The staff member indicated the room is accessible by registered staff and the Environmental Service Manager. The inspector asked S#123 to unlock this area and he was in possession of the key to unlock this area. [s. 130. 2.]

WN #15: 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 comply with O. Regs. 134 (a) whereby the resident's response and effectiveness of a drug was not monitored.

Resident #7's plan of care in effect at the time of this inspection indicated the resident has moderate pain and receives Hydromorphone on an as needed basis for pain management. During the month of February 2014, the resident received the medication on four occasions. The effectiveness was documented three out of four times.

During the month of March 2014, the resident received the medication on eight occasions. The effectiveness was documented three out of the eight times it was administered.

During the month of April 2014, the resident received the medication on four occasions. The effectiveness was documented two out of the four times it was administered. [s. 134. (a)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (12) The licensee shall ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunizations. O. Reg. 79/10, s. 229 (12).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Regs. 79/10, s. 229. (12) in that the licensee has not ensured that pets as part of the pet visitation program have up-to-date immunizations.

On April 14, 2014 Inspector #549 requested a copy of the immunization for the cat that is part of the pet visitation program. The proof of immunization for the cat had expired March 22, 2013. [s. 229. (12)]

Issued on this 24th day of April, 2014

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

Darlene Murphy
Megan MacPhail
Rena Bowen