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

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Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 22, 2013	2013_198117_0001	O-000088-13	Resident Quality Inspection

Licensee/Titulaire de permis

THE GOVERNING COUNCIL OF THE SALVATION ARMY
2 OVERLEA BLVD., TORONTO, ON, M4H-1P4

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

THE SALVATION ARMY OTTAWA GRACE MANOR
1156 WELLINGTON STREET, OTTAWA, ON, K1Y-2Z3

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

LYNE DUCHESNE (117), KATHLEEN SMID (161), PAULA MACDONALD (138)

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): February 4, 5, 6, 7, 8, 11, 12, 13, 14 and 15, 2013, on-site

It is noted that a Critical Incident inspection log # O-000036-13 as well as three Complaint inspections logs # O-000053-13, # O-000073-13 and #O-000135-13, were conducted at the same time as the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with over 40 residents of the home, several resident family members, the Presidents of the Resident and Family Councils, Executive Director, Director of Care (DOC),

Registered Dietitian, Director of Food Services, Director of Environmental Services, maintenance staff member, Director of Life Enrichment, Employee Benefits Coordinator, Business Clerk, Volunteer Services Coordinator, Geriatric Nurse Specialist, several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), several Food Service Workers, several housekeeping aides, a receptionist as well as several volunteers.

During the course of the inspection, the inspector(s) observed resident care and services on all five units; observed the lunch time meal service of February 4, 11 and 12, 2013, and the evening meal service of February 11, 2013; observed resident medication administration; reviewed the health care records of over 40 residents; examined over 40 resident rooms, bathrooms and common areas such as the tub/shower rooms, dining rooms and serveries; examined the home's resident-staff communication response system; reviewed the home's Staffing Schedule; reviewed the home's cleaning routines in food services and housekeeping; reviewed the home's maintenance program, reviewed the home's following policies: Policy # E33 - Catheterization and Catheter Care (January 2013), Policy #A11 - Zero Tolerance of Abuse and Neglect (revised March 2011), Policy #G16 - Medication Administration (revised January 2013), Policy #AM47- Program Plan Ottawa Grace Manor, Policy #A3 - Quality Improvement Framework (October 2012), Policy # AM12 - Management of Complaints (revised November 2010, Policy - Tuberculosis Screening for Staff and Volunteers (January 2013), Policy - Tuberculosis Screening for Residents (January 2013), Policy #HR15- Hiring (October 2012), Policy - Pneumovax Vaccine; as well as the Activity Programs for February 2013.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention
Family Council
Food Quality
Hospitalization and Death
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Reporting and Complaints
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 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 failed to comply with LTCHA, 2007 S.O 2007, c.8, s. 15. (2) (a) in that the licensee failed to ensure that the home, furnishing, and equipment are clean.

A tour of the dining rooms demonstrated that four of six soiled linen carts were unclean in that the metal bin frames and bin lids were heavily coated with various coloured dirt and grime. Discussion was held with a housekeeping aide #S158 who stated that the soiled linen carts in the dining room used to be cleaned by the food service workers until their hours were reduced almost a year ago. The housekeeping aide#S158 further stated that the cleaning of the soiled linen carts was a duty that had not been assigned for the past year and thus it was not being done. The task of cleaning the soiled linen carts was not outlined in the housekeeping job routine or the dietary job routine/cleaning list.

The serveries in the dining rooms were toured on all units. It was observed on all five units that the upper cupboards in the serveries had a sticky, discoloured, unpleasant film that was heavier at the cupboard handles. The lower cupboards in the serveries were also soiled and splattered with debris. It was also noted in each servery that the Garland oven was dirty in that the handle was sticky, the ovens had a yellow film, and that there was dried debris on and in the ovens. Discussion was held with a food service worker #S115 who confirmed that it was the food service worker's responsibility to clean the cupboards and ovens. The cleaning schedule confirmed that this was done as did the Director of Food Service. (log #O-000135-13)

The dining room and servery floors (including the support room) throughout the five units in the home were all observed to have a buildup of brown/black grime in the crease between the floor and baseboards, the flooring near the carpeted hallway, the flooring around the concrete poles, and in the corners. The buildup of grime was more pronounced in the creases near the servery and patio doors, the corners, and under food service equipment in the serveries.

The baseboards were also observed to be dirty with black grime throughout the dining rooms and serveries. The housekeeping aide #S158 stated that baseboards in the dining room are only spot cleaned and also stated that they are not deep cleaned on a routine basis.

Throughout the inspection it was observed that the area in the dining rooms where the dish clearing carts are stored, by the patio doors on each unit, were heavily soiled with

splattered, multi coloured substances including the patio door, patio door sill, flooring, walls, and base boards. This area was exceptionally soiled on 3 Rosemount. In addition, on 3 Wellington it was observed that the window and the blinds directly to the left of this area were also heavily soiled. Discussion was held with a housekeeping aide regarding the cleaning of the dining room, particularly the area near the patio doors. The housekeeping aide #S158 stated that this area was cleaned by the food service worker until their hours were reduced almost a year ago. The housekeeping aide #S158 confirmed that it was now the housekeeping aide's responsibility to clean this area and confirmed that it is a part of the job routine. The housekeeping aide #S158 further stated that this area may not be cleaned everyday but spot cleaned when needed.

On February 5 to 8, 2013 during stage 1 of the Resident Quality Inspection it was observed that the dining room tables on 1 Gladstone were unclean. All seven tables were observed to be have splattered substances and grime of the table top edges and table legs. These tables stayed in this condition throughout the remainder of the inspection until February 15, 2013. Discussion was held with the Director of Food Services and the Director of Environmental Services and both confirmed that it is the food service workers' responsibility to clean the dining room tables including the edges and legs. The job routine provided by the Director of Food Services confirmed that this duty was a responsibility of the early food service worker. Discussion was held with the early food service worker on Gladstone regarding cleaning of the dining room tables and this person stated that only the table tops are cleaned and that the housekeeping staff are to clean the remainder of the tables. The unit housekeeping aide stated that housekeeping is not responsible for cleaning any part of the dining room tables.

A previous inspection, 2012_198117_0004, was conducted and resulted in a written notification for LTCHA, 2007 S.O 2007, c.8, s. 15. (a) relating to the lack of cleanliness in the dining room on Queen's unit. This inspection was conducted more than three months ago on October 24, 25, 29 and 30, 2012. The lack of cleanliness continued to be an observation made during this current Resident Quality Inspection.

While conducting the Resident Quality Inspection, inspector #117 was approached by a family member to express concerns about the home. One of these concerns brought forward related to the lack of cleanliness of the home including the dining room on Rosemount. [s. 15. (2) (a)]

2. The licensee failed to comply with LTCHA, 2007 S.O 2007, c.8, s. 15. (2) (c) in that the licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

During the course of the inspection all three inspectors observed resident common areas and some resident rooms including their washrooms. It was noted in all the spa rooms that the walls were damaged with several holes throughout. Specifically:
- Gladstone - spa had several holes in the wall under the paper towel dispenser.
- Queen's - walls in the unit's shower room were heavily scuffed and marked with several holes varying in size between a few cm to the size of a fist. The holes were at various heights. The walls on both sides of the entrance to the spa, on the shower room side, had holes, gouges, peeling paint and scrapes in the drywall.
- Parkdale - walls near shower entrance door and shower room were heavily scarred and a hole the size of a twoonie was observed in the wall near the door stopper. There was a large hole about 10 in x 5 in the wall behind the second entrance door and the door stopper was observed to be push back into the drywall. The wall was also heavily scuffed and marked. It was observed in the tub room that there were five large holes penetrating the drywall.
- Wellington - walls inside both entrances to the spa room were missing plaster and paint. The walls in the tub room were the same and also have multiple gouges.
- Rosemount - walls in spa area were heavily scarred and have several holes and several patches to the walls in the lift storage area, the spa entrance, and the bath area (nineteen patches just in the area where the lifts were stored). The patches have not been completed in that they have not been sanded or painted. In addition, five of the patches in the lift storage area have been damaged and now have holes.

It was also observed in the shower on Gladstone, Wellington and Rosemount, that there was a short, white bar that was heavily corroded and was causing staining to leach down the shower tile.

In addition to the spa rooms, several resident rooms were observed and it was noted that the walls were in disrepair. Specifically:
- Gladstone 156 - the paint and drywall below the hand sanitizer dispenser was pulled off and not repaired.
- Gladstone 160 – the washroom wall was heavily scarred and had a small hole.
- Gladstone 178 – this is a shared room and the room on the left side had heavy

scarred and paint removed along the wall, one foot above the baseboard.
- Gladstone 187 – the washroom wall was heavily scarred.
- Gladstone 188 - the washroom wall was heavily scarred with paint removed.
- Parkdale 240 – walls in room and bathroom were scuffed at the level of resident wheelchair wheels. There was a hole in the lower wall by the room door 2cm x 5 cm located under the light switch of the room
- Parkdale 267 – there was damaged drywall along the bottom of washroom wall along with three small holes.
- Parkdale 274 – heavy damage along the drywall opposite residents bed over an approximate length of eight feet. There were several scrapes, gouges, and large holes.
- Queen's 226 – walls in the room were heavily scuffed with cracked and peeling paint.
- Wellington 303 – the counter in the washroom was cracked.
- Wellington 304 – the walls in the room and bathroom were gouged and paint is missing.

Discussion was held with the Director of Environmental Services regarding the spas and resident rooms. The Director of Environmental Services acknowledge that he was aware of the conditions of the wall and stated that it was impossible to keep up with the repairs as the home only has one regular maintenance staff member. He stated that he plans to look at some of the areas to determine if paneling on the walls is required.

The dining room floors on 3 Wellington and 3 Rosemount were damaged at the area of the patio doors. In Rosemount, the dining room flooring was observed to be lifting and ripped with the presence of holes and cracks approximately ten to twelve feet along the edge of the flooring by the patio door. In Wellington, the dining room flooring was observed with the same issues as Rosemount but over a larger area of approximately twenty feet. Discussion was held with the Director of Environmental Services and the maintenance staff member and both stated that the damage to the floors occurred in a previous year (neither could recall the year) when there was a heavy snowfall that caused excess accumulation of snow on the balconies. The snow melted and leaked through the bottom of the patio doors damaging the flooring. The dining room floor on 1 Gladstone was also observed to be damaged in that there were many deep scratch-like grooves in the floor that prevents the floor from being properly cleaned. The Director of Environment stated that there is a plan to begin to replace some of the flooring in the dining rooms in the upcoming fiscal year.

All the dining room tables in four out of five units were heavily scarred and worn on the wood portion of the table legs and table top edges. More than three quarters of the dining room chairs throughout the building also had heavily scarred and worn wooden legs. The maintenance staff member acknowledged that the dining room tables and chairs require refinishing and that the home plans to do this internally. The maintenance staff member further stated that six dining room tables had been purchased and set up three months ago for 3 Rosemount unit. This will provide the home with six additional tables to be able to rotate through as tables are being refinished. The maintenance staff member confirmed that no dining tables or chairs have been refinished at this time.

It was observed in all five units that the wood work located on the outside of the nursing station and the resident lounge area was scarred and damaged. The maintenance staff member stated that he was aware of the damage and had plans to repair the damage himself.

It was also observed that some of the wicker furniture placed in the resident lounge area was in disrepair. Specifically, on Queen's, the wicker weave on the bench was broken and becoming unravelled. On Wellington, the wicker weave had broken on the leg of the couch and was unravelling as was the wicker on the arm of the chair. On the Rosemount unit, the wicker weave was broken on the couch and the side of the chair.

On a specified day in January 2013, resident #222 sustained an injury to their arm during a bath as a result of an uneven sharp edge on the tubchair arm. The resident's family member reported that the tub chair was not removed, that the tub chair was only fixed a week after the resident received the injury, and that the resident had a second bath in the damaged tubchair. The 24 hour report and unit communication book were reviewed and there was no documentation regarding any safety concerns of the tubchair. The resident's chart was reviewed and it confirmed that the resident had another bath three days later after the injury. A PSW was interviewed and stated that the tub chair with the damaged arm was not removed from the unit and had been used to bathe residents. Discussion was held with the maintenance staff member who was able to demonstrate through the maintenance log that he received a request 7 days after the resident's injury to repair the arm of the tubchair. The maintenance staff member stated that any repair request relating to resident safety is a priority and

he immediately followed up with the tubchair once notified. He further stated that he completed a temporary repair to the tubchair on the day he was notified and that a replacement chair is forthcoming. (log #O-000073-13) [s. 15. (2) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (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 comply with LTCHA s.6 (4) (a) and (b) in that the staff and others involved in the different aspects of care of the resident collaborate with each other a) in the assessment of the resident and b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent and compliment each other

Resident #166 has a Foley catheter and is identified as being at high risk of urinary tract infections. Resident #166 receives the services of a medical specialist. Resident #166 was also recently hospitalized with an infection. In November, 2012, the medical specialist made recommendations related to the resident's Foley catheter. Progress notes document a discussion was held between the evening RN and the resident's POA in regards to this recommendation. RN advised POA that the recommendations would be brought to the attention of the resident's attending physician. The RN noted that catheter care best practices would include that the resident have a day and night urinary drainage bag and that the bags be cleansed with white vinegar and water between alternate usages. Progress notes also document the evening RN advising unit RPN to initiate the use of night and day drainage bags as well as the vinegar and water cleansing process as part of the resident's plan of care.

A review of resident #166's plan of care shows that there are no directives related to the care and cleansing of the urinary drainage bag. Staff member #S146 states that the drainage bag should be cleansed on a daily basis with vinegar and water. Unit staff member #S147 states that the staff have been rinsing the resident's drainage bag with only water. Staff members #S146 and #S147 searched unit, no vinegar and no night drainage bags were on the unit. The resident's POA stated that as per previous discussion with unit nursing staff, the nursing staff were to cleanse the urinary drainage bag with vinegar and water on a daily basis.

The resident #166's plan of care does not include the status of the medical specialist's recommendations, nor those discussed between unit nursing staff and the resident's POA related to the care and cleansing of urinary drainage bags. [#117] [s. 6. (4)]

2. On a specific date in January, 2013, resident # 222 sustained an injury to their arm during a bath. The tub chair arm had an uneven sharp edge with caused the injury. A dressing was applied and dated the day of the injury. The RPN working at that time had to leave the home unexpectedly. The RPN did not document the resident's injury in the resident's health care record and did not communicate to other registered and

non-registered nursing staff information related to the resident's injury.

Five days later in January, 2013, progress notes document that the RPN on duty at that time was not aware of the resident's injury and dressing. There is no documentation in the resident's health care record of the resident's injury, dressing and monitoring of the injury. Interviewed staff members #S157 and #S153 state that they were not informed at shift report of the resident's injury and dressing. Nursing shift reports and the 24-hour nursing communication book have no information related to the resident's injury and post-injury wound assessment and monitoring. (log # O-000073-13)[#117] [s. 6. (4) (a)]

3. The Licensee failed to comply with LTCHA s. 6 (7) in that the care set out in the plan of care was not provided to the resident as specified in the plan.

Resident #166 is identified as being at high risk for falls. The resident's plan of care specifies that the resident is to have a bed/chair alarm as a fall prevention intervention. This was confirmed by staff member #S146. On February 12, 2013, it was observed that the resident did not have a bed/chair alarm. The resident and his/her family member stated that the resident has not had a bed/chair alarm for approximately 2 months as it was broken and not replaced. Staff member #S147 stated that they had reported to the RN that the resident's bed/chair alarm was broken a few months ago and that to their knowledge it had not been repaired or replaced. On February 15, 2013, the DOC stated to Inspector #117 that resident #166 did have a bed/chair alarm as a fall prevention intervention. She indicated that this was removed several months ago when the resident was very agitated. She indicated that she was not aware of the status of the use of the bed/chair alarm since it's removal several months ago. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff collaborate with each other in the assessment, development and implementation of the plan of care as it relates to catheter and wound care; and also to ensure that the fall prevention interventions set out in the plan of care is provided to the resident, 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.Reg 79/10, s.8(1)(b) to ensure that their policies are complied with.

As required by O.Reg 79/10 s. 114(2) the licensee has a policy that provides for the administration of medications to residents. The licensee has failed to ensure that this policy was complied with as demonstrated by the findings below.

The Home's policy "Medication Administration" #G16 states that the College of Nurses of Ontario Medication Practice Standards applies to the Registered Nursing staff administering medication to residents at Grace Manor.

The College of Nurses of Ontario Medication Practice Standards indicates that the documentation of medication administration should be done after the medication has been administered to the resident.

On February 6, 2013 at 08:04 on the Wellington unit, Inspector #161 observed staff member #S135 administer medications to residents # 36, # 40, # 41. Staff member #135 prepared the medications to be administered, and was observed to sign the electronic Medication Administration Record (eMAR) indicating that the medication was administered prior to giving the residents' their prescribed medication. She then proceeded to locate the residents and administered their medications. Staff member #S135 stated to Inspector #161, that she pre-signs the eMAR so as to secure access to the eMAR before going to give the residents their medication. If the resident refuses the medication she states that she then goes in the eMAR system and changes the entry to resident refusal of medication. [#161]

On February 6, 2013, Inspector #117 observed staff member #S159 on Queen's Unit give medication to 3 residents #234, #235 and # 236. Staff member #S159 verified the medication to be given with eMAR and was observed to sign the eMAR indicating that the medication was administered prior to giving the residents' their prescribed medication. Staff member #S159 stated to MOH inspector #117, that she pre-signs the eMAR as the electronic system will lock her out before going to give the residents their medication. If the resident refuses the medication she states that she then goes in the eMAR system and changes the entry to resident refusal of medication. [#117]

February 14, 2013 at 14:30, discussion with the DOC who indicated to the inspector that staff the members #S135 and #S159 had not followed the home's Medication

Administration Policy #G16 by pre-signing the medication as administered before it had occurred. [s. 8. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the documentation of medication administration will be done after the medication has been administered to the resident, to be implemented voluntarily.

WN #4: 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 failed to comply with O. Reg 79/10, s. 17 (1) (a) in that the licensee did not ensure that the home's resident-staff communication and response system can be accessed and used by residents, staff and visitors at all times.

On February 5 to 8, 2013, stage 1 of the Resident Quality Inspection was conducted. During stage 1, ten resident rooms were identified to have call bells that did not function properly in the resident washrooms.

Further auditing of the call bells located in the resident washrooms was conducted on February 12, 2013, throughout all units of the home. It was observed that ten of twenty six call bells in resident washrooms did not function properly because the cord attached to the call bell could not be pulled and, thus, the call bell could not be engaged. These call bell cords were clipped to a handrail and positioned in a way that prevented the cord from engaging the call bell.

Discussion was held with the Director of Environmental Services and a maintenance staff member. Three additional resident washrooms were visited with the Director of Environmental Services and the maintenance staff member and it was observed, in all three washrooms, that the call bell cord was clipped to the handrail and positioned in a way that prevented the cord from engaging the call bell. Both the Director of Environmental Services and the maintenance staff member acknowledged that these three call bells were not set up properly. The maintenance staff member was able to demonstrate the intended set up which allowed the call bell cord to be pulled to engage the call bell. [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 that the home's resident-staff communication and response system in resident washrooms is set up to enable the call bell to be engaged, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s.30 (1)1 in that the licensee did not ensure that the following is complied with in respect to each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O.Reg 79/10 s. 30(1)1.

As per O. Reg 79/10 s. 48 (1) the licensee shall ensure that there is a pain management program to identify pain in residents and manage pain.

On February 12, 2013 discussion held with the home's Director of Care. She indicated to inspector #161 that the home does have a pain management program to identify pain in residents and manage their pain however, the home does not have a written description of this program. She assured inspector #161 that she would write a description of their pain management program.

2. The program must be evaluated and updated at least annually in accordance with evidence based practices and, it there are none, in accordance with prevailing practices. O.Reg. 79/10 s.30(3).

As per LTCHA 2007 S.O. 2007, c.8, s.16(1) the licensee shall ensure that there is an organized volunteer program for the home that encourages and supports the participation of volunteers in the lives and activities of the residents.

The organized volunteer program is not evaluated and updated at least annually.

On February 13, 2013 discussion was held with the home's Volunteer Coordinator who indicated to inspector #161 that the home's Volunteer Program has not been evaluated or updated in the 2 years she has been in this position. She indicated she was aware it needed to be done. [s. 30. (1) 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 there is a written description of the home's pain management program as well as to ensure that the home's organized volunteer program be evaluated and updated at least annually in accordance with evidence based practices or in accordance with prevailing practices, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, s. 72. (3) (a) in that the licensee failed to ensure that all foods in the food production system are prepared, stored and served using methods to preserve taste, appearance, and food quality.

It was noted that at each of the three meal services observed that individual texture modified menu components were held together in pans in the steam cart. This caused the individual menu components to become mixed together thus compromising their taste, appearance and quality. For instance, it was observed on February 11, 2013 at the dinner meal on 2 Queen's that the minced chicken and the minced peas were held in the same pan in the steam cart as was the minced beef and minced squash. It was observed that as the dinner service progressed the minced peas became mixed with the minced chicken in the pan in the steam table. A resident on the unit requiring minced texture with a dislike to chicken was not able to request the minced peas as the peas had become mixed with the minced chicken. It was also noted on February 11, 2013 on 3 Rosemount at lunch time that the pureed fish was held in the same pan as the pureed potato. It was observed that as the meal progressed the pureed potato and pureed fish in the pan in the steam cart became mixed together and was served to residents mixed instead of two separate menu components as indicated by the menu.

Discussion was held with the Director of Food Services and he confirmed that this practice of putting multiple menu components in one pan for the meal service was initiated approximately a year ago in an attempt to create efficiencies in food production. [s. 72. (3) (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 that the texture modified foods in the food production system be stored and served using methods to preserve taste, appearance and food quality., to be implemented voluntarily.

WN #7: 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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours. O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 107 3 (4) to inform the Director no later than one business day after the occurrence of the incident of an injury in respect of which a person is taken to hospital.

On a specified day in November, 2012 Resident #39 fell, sustained an injury and was transferred to hospital. The resident was transferred back to the home later on the date of injury. The home notified the Director via the Critical Incident Reporting System four days after the resident's injury and transfer to hospital. [Log # O-000036-13] [s. 107. (3)]

2. The Licensee failed to comply with O.Reg. 79/10 s. 107 (5) in that the resident's substitute decision maker was not promptly notified of a serious injury or illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified.

On a specified day in January, 2013, the resident #222 sustained an injury to their arm while being given a bath. The resident's plan's of care indicates that the resident's POA is to be notified of any change in the resident's health status. Five days later, the resident's POA visited the resident and discovered the resident's injury. No evidence was found in the resident's health care record nor in the home's 24-hour Nursing report indicating that the home had notified the POA of the resident's injury. The resident's POA was not notified of the resident's injury. [log # O-000073-13]

A previous inspection, 2012_198117_0004, was conducted on October 24, 25, 29 and 30, 2012, and resulted in a written notification for O.Reg. 79/10 s. 107 (5) in that a resident's substitute decision maker (SDM) was not promptly notified of a serious injury or illness of a resident, in accordance with any instructions provided by the SDM. [s. 107. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that Critical Incidents related to resident injuries and requiring transfer to hospitals are reported to the Director as per legislation; and to ensure that residents' substitute decision makers (SDM) are notified of any serious injury or illness of the resident, in accordance with any instructions provided by the SDM, to be implemented voluntarily.

WN #8: 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 failed to comply with O.Reg 129 (1) (a) as it relates to drugs being stored in an area or medication cart, i) that is used exclusively for drugs and drug-related supplies.

On February 8, 2013, the home's maintenance staff member and staff member #S121 showed Inspector #117 the home's medication stock storage room, located in the home's basement. The storage room contains not only drugs and drug related supplies but is used as the home's main continence care supplies storage area. [#117]

The Rosemount unit medication cart narcotic box was observed by Inspector #161 to have two $100 bills in the narcotic box. The staff member #S125 states that this belongs to a staff member who asked her to hold it for her until the end of shift. The staff member #S125 stated that she has also stored a gold necklace for this staff member in the past. [#161] [s. 129. (1) (a)]

2. The Licensee failed to comply with O.Reg 129 (1) (a) as it relates to drugs being stored in an area or medication cart, ii) that is secure and locked.

On February 6, 2013, at 11:59, a medication cart was observed to be unlocked and unattended for several minutes beside the Queen's unit dining room. The staff member #S159 had gone to get a medication in the unit's medication room. Several residents were observed to be circulating to the dining room and passing beside the unlocked medication cart. [#117]

On February 15, 2013, at 08:00 Inspector # 161 observed the medication cart on the Wellington unit to be unlocked, unattended. It was noted that a bottle of Lax –a- day was on the top of the medication cart. Staff member #S135 was in the adjacent resident lounge and unable to observe her medication cart. [#161] [s. 129. (1) (a)]

3. The Licensee failed to comply with O.Reg 129 (1) (a) as it relates to drugs being stored in an area or medication cart, iv) that complies with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting).

On February 7 and 8, 2013, it was noted that in Queen and Parkdale units' medication rooms that Glycerine and Dulcolax suppositories were being kept in the medication room refrigerators. Package directions indicate that the suppositories are to be kept

out of the heat and kept at temperatures between 15-30 degrees Celsius. [#117]

On February 7, 2013, Inspector #161 observed that the Wellington unit medication refridgerator contained 1 box of 12 Glycerine suppositories. The directions for storage on the box states "store between 15-30 degrees". The home's attached medication fridge thermometer indicates current temperature is 9.9 Celsius. The refrigerator also contained 2 vials of Lorazepam injectable (4 mg each) with an expiry date of 2010/11. [#161]

On February 7, 2013, Inspector # 161 noted that the following medication, kept in the Rosemount and Wellington units medication carts and medication rooms, were expired.

- Rosemount medication cart was observed to contain 1 tube of Finacea 15% cream with an expiry date of 2012/04.

- Rosemount medication refridgerator was observed to contain 1 box of 78 Bisacodyl 10 mg suppositories with an expiry date of 2011/07

- Rosemount medication cupboard was observed to contain 1 Accuchek Compact Autocontrol Solution with an expiry date of 2012/08 and 1 bottle of Calamine lotion with an expiry date of 2012/08;

- Rosemount emergency drug box was unlocked and kept in cupboard in the unit's medication room. It was observed to contain 2 tablets of Lorazepam 1 mg with an expiry date of 12/12; 2 Tylenol 650 mg suppositories with an expiry date of 2013/01; 7 Clindamycin 150 mg tabs with an expiry date of 2013/01

- Wellington medication cart was observed to contain 1 vial of Morphine 15 mg injectable with an expiry date of 2011/12

- Wellington medication room refridgerator was noted to contain 2 vials of Lorazepam injectable (4 mg each) with an expiry date of 2010/11.

- Wellington medication cupboard was observed to contain 1 bottle of Calamine lotion expiry date 2012-08; 1 bottle Dimenhydrinate Syrup expiry date of August 2011; Accuchek Auto Control expiry date August 2012; 3 boxes of Gravol 50 mg

suppositories (10/box) with the following expiry dates – boxes #1 and #2 with expiry dates of 2012/10, box #3 expiry date 2012/06; 1 box of 12 Anuzinc suppositories with expiry date of 2011/10

- Wellington emergency drug box was unlocked, and kept in cupboard in the unit's medication room. The emergency drug box contained 7 Clindamycin 150 mg tabs with an expiry date of 2013/01; and 2 tabs of Lorazepam 1 mg with expiry date of 12/12. [#161]

24 Hour Nursing Report dated January 15, 2013, documents that staff member #S121 found an open vial of Tuberculine injection improperly stored in the Parkdale medication room refrigerator. The report indicates that there was no documentation indicating when the vial was opened, by whom or its expiry date (usually 30 days post opening). The vial was disposed of. Staff member #S121 also reminded registered staff that Tuberculine injections are to be stored in one identified refrigerator that remains between 2 and 8 degrees Celsius, this to ensure its potency. [#138] [s. 129. (1) (a)]

4. The Licensee failed to comply with O.Reg. 129 (1) (b) as it relates to controlled substance 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.

On February 7 and 8, 2013, it was noted that residents prescribed benzodiazepines, which are controlled substances, are not stored in a separate locked area within the locked medication carts. This was confirmed by two staff members #S124 and #S123.

On February 8, 2013, it was noted by Inspector #117 that Diazepam 10mg/2ml vials, Haloperidol 5mg/ml vials and Lorazepam 1mg po / tab are kept in the Parkdale and Queen resident care units emergency drug boxes. The emergency drug boxes are not locked and they are stored in an unlocked drawer of the Queen and Parkdale unit medication rooms. [#117]

On February 7, 2013, Inspector #161 observed that the Wellington unit medication refrigerator contained 2 vials of Lorazepam injectable (4 mg each) with an expiry date of 2010/11.

Inspector #161 observed that the emergency drug box on Rosemount unit was noted

to be unlocked and kept in a cupboard in medication room. It was observed to contain 2 tablets of Lorazepam 1 mg with an expiry date of 12/12

Inspector #161 observed that the emergency drug box on Wellington unit was noted to be unlocked and kept in a cupboard in this room. It was observed to contain 2 tablets of Lorazepam 1 mg expiry date of 12/12. [#161]

The above mentioned medications are controlled substances and they are not stored in a separate double locked stationary cupboard, in a locked area. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that medication carts are locked as per the home's policies, that only drugs are stored in medication carts, that expired medication be removed from medication rooms, that medication be properly stored as indicated by the manufacturers and finally that all controlled substanced, including benzodiapines, are double locked, to be implemented voluntarily.

WN #9: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

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

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 s.229.(10)1 in that each resident admitted to the home was not screened for Tuberculosis within 14 days of admission.

Resident #16 was admitted to the home on a specific date in March, 2012. It is documented in the Grace Manor Immunization report that the first step of the resident's Mantoux skin test was administered on on a specific date in May, 2012 (59 days after admission).

Resident #17 was admitted to the home on a specific date in May, 2012. It is documented in the Grace Manor Immunization report that the first step of the resident's Mantoux skin test was administered on a specific date in June, 2012 (36 days after admission).

Resident #19 was admitted to the home on a specific date in January, 2012. It is documented in the Grace Manor Immunization report that the first step of the resident's Mantoux skin test was administered on a specific date in February, 2012 (19 days after admission).

Resident #20 was admitted to the home on a specific date in June, 2012. It is documented in the Grace Manor Immunization report that the first step of the resident's Mantoux skin test was administered on a specific date in August, 2012 (76 days after admission).

2. The licensee failed to comply with O. Reg. 79/10 s.229. (10) 3. in that residents are not offered immunizations against Tetanus and Diphtheria as demonstrated by the following findings.

On February 13, 2013, the Director of Care reported that the home does not offer residents immunization against Tetanus and Diphtheria. [s. 229. (10) 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 each resident who is admitted to the home must be screened for Tuberculosis within 14 days of admission and documented the results of the screening as well as to ensure that residents be offered immunizations against Tetanus and Diphtheria in accordance with publicly funded immunization schedules, to be implemented voluntarily.

WN #10: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA s. 3 (1) 11 (iv) in that residents of the home have the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 are kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

On February 6, 2013, on the Wellington unit, Inspector #161 had a discussion with staff member #S135 who indicated to the inspector that after she administers a medication, she disposes the empty medication package, on which is noted the resident name, room number and medication information, in the clear garbage bag attached to her medication cart. When the garbage bag is full, staff member #S135 indicates she throws the garbage bag into the housekeeper's garbage when the housekeeper passes by. [#161]

On February 6, on the Queen's unit, Inspector #117 observed the staff member #S159, administer medication to three residents,#234, #235 and # 236. Staff member #S159 was observed to dispose of the residents' administered empty medication packages in the garbage bin attached to the medication cart. Several other residents' discarded empty medication packages were observed in the garbage bin. Resident names, room number and medication information are labeled on each of the medication packages. Staff member #S159 stated that the garbage, including the empty medication packages, are disposed of in the home's regular garbage. [#117]

On February 13, 2013 on the Wellington unit, Inspector #161 observed staff member #S132 remove the clear garbage bag, attached to her medication cart, containing empty medication packages on which where resident names, room numbers and medication information, and place it in the garbage bag on the unit. The Executive Director was on the unit at the time of the observation. Inspection #161 showed him the disposed medication packages containing residents' personal health information. [#161]

Residents' personal health information, noted on resident medication packages is not kept confidential when being disposed of in the home's garbage disposal system. [s. 3. (1) 11. iv.]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)

(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O 2007, c.8, s. 78 (2) (n) in that the licensee failed to include in the package of information provided to the resident or substitute decision maker at the time of the resident's admission a disclosure of all the non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs, or goods to residents.

The admission package was provided by the Director of Care and the resident agreement provided by the Business Clerk. These documents were reviewed and it was observed that there was no disclosure regarding all of the licensee's non-arm's length relationships and other providers who may offer care, services, programs, or goods to residents.

Discussion was held with the Business Clerk and the Director of Care regarding disclosure of the non-arm's length relationships in the admission package. Both the Business Clerk and the Director of Care were unable to confirm that this information was enclosed in the package at admission. [s. 78. (2) (n)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.

2. Access to these areas shall be restricted to,

i. persons who may dispense, prescribe or administer drugs in the home, and

ii. the Administrator.

3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The Licensee failed to comply with O.Reg s.130 (2) as it relates to the home ensuring that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On February 8, 2013, staff member #S121 showed to Inspector #117, the home's government medication stock storage area. The area also contains the home's continence care supplies. Staff member #S121 stated that the home's maintenance staff member also has a key to the medication storage area. The home's maintenance staff member, confirmed that he has a key to open and access the home's government medication storage area. He stated that he regularly accesses the storage area to deliver and store the home's continence supplies. [s. 130. 2.]

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

Issued on this 22nd day of February, 2013

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

Lynn Dochesne #117

Paula MacDonald RD #138

Kathleen Snid #161

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNE DUCHESNE (117), KATHLEEN SMID (161), PAULA MACDONALD (138)
Inspection No. / No de l'inspection :	2013_198117_0001
Log No. / Registre no:	O-000088-13
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 22, 2013
Licensee / Titulaire de permis :	THE GOVERNING COUNCIL OF THE SALVATION ARMY 2 OVERLEA BLVD., TORONTO, ON, M4H-1P4
LTC Home / Foyer de SLD :	THE SALVATION ARMY OTTAWA GRACE MANOR 1156 WELLINGTON STREET, OTTAWA, ON, K1Y-2Z3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	DERRICK GULLAGE

To THE GOVERNING COUNCIL OF THE SALVATION ARMY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # /
Ordre no : 001

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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).

Order / Ordre :

The licensee is to ensure that the dining rooms and serveries (including the support room) on all units are cleaned including the flooring, baseboards, walls, windows and blinds (where necessary), patio doors, dining room furniture, soiled linen carts, servery cupboards, and servery ovens.

Grounds / Motifs :

1. The licensee failed to comply with LTCHA, 2007 S.O 2007, c.8, s. 15. (2) (a) in that the licensee failed to ensure that the home, furnishing, and equipment are clean.

A tour of the dining rooms demonstrated that four of six soiled linen carts were unclean in that the metal bin frames and bin lids were heavily coated with various coloured dirt and grime. Discussion was held with a housekeeping aide #S158 who stated that the soiled linen carts in the dining room used to be cleaned by the food service workers until their hours were reduced almost a year ago. The housekeeping aide #S158 further stated that the cleaning of the soiled linen carts was a duty that had not been assigned for the past year and thus it was not being done. The task of cleaning the soiled linen carts was not outlined in the housekeeping job routine or the dietary job routine/cleaning list.

The serveries in the dining rooms were toured on all units. It was observed on all five units that the upper cupboards in the serveries had a sticky, discoloured,

unpleasant film that was heavier at the cupboard handles. The lower cupboards in the serveries were also soiled and splattered with debris. It was also noted in each servery that the Garland oven was dirty in that the handle was sticky, the ovens had a yellow film, and that there was dried debris on and in the ovens. Discussion was held with a food service worker #S115 who confirmed that it was the food service worker's responsibility to clean the cupboards and ovens. This was confirmed by the cleaning schedule and the Director of Food Services. (log #O-000135-13)

The dining room and servery floors (including the support room) throughout the five units in the home were all observed to have a buildup of brown/black grime in the crease between the floor and baseboards, the flooring near the carpeted hallway, the flooring around the concrete poles, and in the corners. The buildup of grime was more pronounced in the creases near the servery and patio doors, the corners, and under food service equipment in the serveries.

The baseboards were also observed to be dirty with black grime throughout the dining rooms and serveries. The housekeeping aide #S158 stated that baseboards in the dining room are only spot cleaned and also stated that they are not deep cleaned on a routine basis.

Throughout the inspection it was observed that the area in the dining rooms where the dish clearing carts are stored, by the patio doors on each unit, were heavily soiled with splattered, multi coloured substances including the patio door, patio door sill, flooring, walls, and base boards. This area was exceptionally soiled on 3 Rosemount. In addition, on 3 Wellington it was observed that the window and the blinds directly to the left of this area were also heavily soiled. Discussion was held with a housekeeping aide #S158 regarding the cleaning of the dining room, particularly the area near the patio doors. The housekeeping aide #S158 stated that this area was cleaned by the food service worker until their hours were reduced almost a year ago. The housekeeping aide #S158 confirmed that it was now the housekeeping aide's responsibility to clean this area and confirmed that it is a part of the job routine. The housekeeping aide further stated that this area may not be cleaned everyday but spot cleaned when needed.

On February 5 – 8, 2013 during stage 1 of the Resident Quality Inspection it was observed that the dining room tables on 1 Gladstone were unclean. All seven

tables were observed to be have splattered substances and grime of the table top edges and table legs. These tables stayed in this condition throughout the remainder of the inspection until February 15, 2013. Discussion was held with the Director of Food Services and the Director of Environmental Services and both confirmed that it is the food service workers' responsibility to clean the dining room tables including the edges and legs. The job routine provided by the Director of Food Services confirmed that this duty was a responsibility of the early food service worker. Discussion was held with the early food service worker on Gladstone regarding cleaning of the dining room tables and this person stated that only the table tops are cleaned and that the housekeeping staff are to clean the remainder of the tables. The unit housekeeping aide stated that housekeeping is not responsible for cleaning any part of the dining room tables.

A previous inspection, 2012_198117_0004, was conducted and resulted in a written notification for LTCHA, 2007 S.O 2007, c.8, s. 15. (a) relating to the lack of cleanliness in the dining rooms on Queen's unit. This inspection was conducted more than three months ago on October 24, 25, 29, and 30, 2012. The lack of cleanliness continued to be an observation made during this current Resident Quality Inspection.

While conducting the Resident Quality Inspection, inspector #117 was approached by a family member to express concerns about the home. One of these concerns brought forward related to the lack of cleanliness of the home including the dining room on Rosemount.
(138)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 25, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 22nd day of February, 2013

Signature of Inspector / Signature de l'inspecteur: Lyne Duchesne #117 Paula MacDonald RP #158 Kathleen Snid #161

Name of Inspector / Nom de l'inspecteur : LYNE DUCHESNE

Service Area Office / Bureau régional de services : Ottawa Service Area Office