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
Aug 8, 14, 2014	2014_284545_0020	O-000717-14	Resident Quality Inspection

Licensee/Titulaire de permis

TAMINAGI INC.
05 Loiselle Street, CP Box 2132, Embrun, ON, K0A-1W1

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

SARSFIELD COLONIAL HOME
2861 Colonial Road, P.O. Box 130, Sarsfield, ON, K0A-3E0

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

ANGELE ALBERT-RITCHIE (545), LINDA HARKINS (126), LISA KLUKE (547), LYNE DUCHESNE (117), MELANIE SARRAZIN (592)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): July 28-29-30-31, August 1-5-6-7-8, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Administrator, Nutrition Manager/Acting Activity Director, Environmental Manager, RAI Coordinator/Acting Director of Care, Registered Dietitian, Pharmacist, several Registered Nurses (RN), several Registered Practical Nurses (RPN), one Physiotherapy Assistant, one Housekeeping Assistant, one Dietary Aide, one member of the Residents' Council, family members and residents.

During the course of the inspection, the inspector(s) conducted a tour of all resident care areas, observed Residents' rooms, observed Resident common areas, observed a medication administration pass and medication storage areas, observed two meal services, reviewed resident health records, staff schedules, relevant home several policies, Residents' Council minutes and observed delivery of Resident care and services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Training and Orientation

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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

The licensee has failed to comply with O.Reg 79/10 s. 131 (3), subject to subsection 4.1 and s. 131 (8) (b) in that the home did not ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

In accordance with O.Reg 79/10 s. 131 (4.1):
A member of the registered nursing staff may permit a nursing student to administer drugs to residents if,

(a) the licensee has verified with the university or college that offers the nursing educational program in which the nursing student is enrolled that the nursing student has received education or training about the administration of drugs as part of the program;

(b) the nursing student has been trained by a member of the registered nursing staff in the written policies and protocols for the medication management system referred to in subsection 114 (2);

(c) the member of the registered nursing staff who is permitting the administration is satisfied that the nursing student can safely administer drugs; and

(d) the nursing student who administers the drugs does so under the supervision of the member of the registered nursing staff. O. Reg. 218/13, s. 1 (2).

And in accordance with O.Reg 79/10 s. 131 (8), in this section, the "nursing student" means a person,

(a) who is enrolled in an educational program, the successful completion of which meets the educational requirements for the issuance of a certificate of registration as a registered nurse or registered practical nurse as set out in the regulations made under the Nursing Act, 1991, and

(b) who is working in the long-term care home as part of the clinical placement requirement of the educational program pursuant to an agreement between the licensee and the university or college that offers the educational program. ("étudiante infirmière ou étudiant infirmier") O. Reg. 79/10, s. 131 (8); O. Reg. 218/13, s. 1 (3).

During the course of the Resident Quality Inspection, Staff #S117 was observed on several day shifts providing care and services to Residents in the home in the capacity of a Personal Support Worker (PSW).

In reviewing staffing schedule for the period of July 19 to August 15, 2014, it was

noted that Staff #S117 was scheduled as Registered Practical Nurse on the following day shifts:
• July 25 & 30, 2014
• August 2, 3, 8 and 13 2014

This home provides care and services to 46 residents on three floors. The registered practical nurse during the day is responsible to administer drugs to all 46 residents, as prescribed.

On August 8, 2014 at 08:20, Inspector #545 observed Staff #S117 administering oral drugs to residents on the 3rd floor. When asked if she was a registered practical nurse (RPN) or a registered nurse (RN), Staff #S117 indicated that she was not a RPN or RN. Staff #S117 indicated she was a nursing student going back to university in September 2014. Staff #S117 indicated that the DOC was aware that she did not have a license to practice as RN or RPN, and that the DOC allowed her to practice as a Registered Practical Nurse, as well as PSW.

On August 8, 2014 at 08:45, during an interview with the RAI Coordinator/Acting DOC, she indicated that she thought Staff #S117 had a temporary license to practice as RPN. In discussion with the Assistant Administrator (Office Manager), she indicated that Staff #S117 had no RPN or RN license, and was not working in this long term care home as part of a clinical placement. The Assistant Administrator added that the DOC had given her permission to schedule Staff #S117 as RPN on all three floors of the home.

On August 8, 2014 at 08:50, during a phone interview with the Administrator, she indicated to Inspector #126 that she was aware that Staff #S117 was not a RPN and that the home was scheduling this staff as RPN. The Administrator indicated that she thought it was acceptable to schedule Staff #S117 in the capacity of RPN being that she was going back to University in September 2014 to finish the nursing program.

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 8 (1) (b) in that the home did not ensure that the any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

As per O.Reg 79/10 s. 48 (1) 2, every licensee of a long-term care home shall ensure that the following interdisciplinary programs is developed and implemented in the home: Skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

The Home's Skin Care Policy (revised May 28, 2013) and Skin/Wound Protocol (revised May 27, 2013) were reviewed by Inspector #545 and Inspector #126 and the following directions were found:

Skin Care Policy: Policy for routine skin assessment and reporting:
•Item 3, under the section Procedure, it was indicated that "If skin condition, sores, ulcers…not improving, the RN/RPN will assure physician is notified either by phone or his next visit by writing comments on 'Weekly Physician visit' form"

Skin/Wound Protocol:
•Item 10 under Procedure indicated: "A photo must be taken for all wounds stage 3, 4 or X initially, monthly and when necessary and kept in "Treatment and Observation Record" and TARS if applicable."
•Item 14 under the section Procedure indicated: "If a Resident has a stage 3 or more; the RN/RPN must notify the DOC and discuss action plan. E.T. can be called for consultation but no longer covered by HIN. If stage 2, treatment will be discussed with physician for appropriate treatment."
•Item 1 under section Procedure for Clean Dressing Change indicated: "Check

physician order for current, correct treatment"
•Item 16 under section Procedure for Clean Dressing Change indicated: "Apply medication as per order of physician and dressing as per recommendation of physician."

Residents #003 and #005 were assessed as having Stage 3 pressure ulcers which are defined as:
A full thickness of skin is lost, exposing the subcutaneous tissues – presents as a deep crater with or without undermining adjacent tissue.

Resident #005 was assessed as having a stage 3 pressure ulcer to a specific area for a period of one year.

Inspector #545 reviewed Resident #005's most recent plan of care. It was indicated under Skin Integrity to do "dressing as per doctor's orders". The only order found on the most recent Physician Medication Review was "Skin Protocol".

No picture of the Stage 3 pressure ulcer of the specific area was found in the "Treatment and Observation Record" and TARS for Resident #005, as per RAI Coordinator/Acting Director of Care.

During an interview with RN #S111 on August 1, 2014 she indicated that she never requested orders for Resident #005's Stage 3 pressure ulcer, added that various treatments were initially tried then by mid-October 2013 an antimicrobial packing was initiated. RN #S111 indicated that 8 months later the treatment was changed to a antimicrobial cream. The RN indicated that the antimicrobial creams were available in the home and that she didn't think she required to consult with the physician for treatment of a Stage 3 pressure ulcer; that the doctor trusted the registered staff with skin care protocols. RN #111 indicated that she was not a Nurse Practitioner or an Enterostomal Therapy (ET) nurse.

On August 5, 2014 during an interview with the RAI Coordinator/Acting DOC, she indicated that the ET nurse would have been consulted by telephone or email and that a photo of the wound would probably have been sent in October 2013 regarding Resident #005's stage 3 pressure ulcer but was unable to find any documentation or photo. She indicated that it was the home's expectation that the ET nurse's recommendations be discussed with the physician and co-signed by this one. [s. 8. (1) (a),s. 8. (1) (b)]

2. Resident #003 had a stage 3 pressure ulcer to a specific area.

During a discussion with RN #S111, she indicated to Inspector #126 that the RAI Coordinator sent a picture (via email) of the pressure ulcer to the Enterostomal Therapy (ET) nurse on a specific date in July 2014 and that the ET nurse had recommended a specific treatment which was started and documented by registered staff on the "Treatment and Observation Record".

On July 31, 2014, the RN #S111 indicated that the home had not consulted and obtained an order from the physician to administer the treatment. A telephone order was obtained on August 1, 2014 for the specific treatment. (126) [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place for Skin and Wound Care Program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg s. 50.(2) (a)(ii) in that the licensee did not ensure that resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

Resident #003 was admitted to the hospital on a specific date in July 2014 and returned to the home three days later. Resident #003 had Stage 3 pressure ulcer to a specific area prior to discharge to the hospital. Resident #003's dressing was changed the day after returning from hospital and no documentation was completed related to the skin assessment as per the home's policy.

On August 5, 2014, discussion with RN #S111, indicated that Resident #003's skin assessment was still not completed as required by the policy as of today. [s. 50. (2) (a) (ii)]

2. The licensee has failed to comply with O.Reg 79/10 s .50 (2) (b) (iv) in that the home did not ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #005's assessment prior to hospitalization one year ago demonstrated that he/she was totally dependent for all activities of daily living with severe cognitive impairment. As per a review of the doctor's orders, it was documented that upon the return from hospital, palliative care was initiated.

As per a review of the "Skin Care Management - Treatment and Observations Record", it was documented that Resident #005 returned from hospital one year ago with an unbroken blood blister to a specific area.

In the last year, the pressure ulcer's healing process was documented as follows on the "Skin Care Management - Treatment and Observations Record":
-A specific date in October 2013: stage 3 ulcer
-A specific date in November 2013: stage X ulcer
-A specific date in December 2013: foul drainage, swab taken and sent to lab
-A specific date in May 2014: stage 2 ulcer
-A specific date in June 2014: increased in size
-14 days later in June 2014: foul drainage
-12 days later in June 2014: swab taken and sent to the lab
-2 days later in July 2014: stage X ulcer
-A specific date in July 2014: stage 3 ulcer

During an interview with RN #S111, she confirmed that weekly skin assessments were not done weekly between Resident #005's return from hospital one year ago and the end of July 2014 when Resident #005 was exhibiting a pressure ulcer to a specific area that was not healing:
-September 2013: weekly assessments were done 1 out of 4 weeks
-October 2013: weekly assessments were done 3 out of 4 weeks
-November 2013: weekly assessments were done 1 out of 4 weeks
-January 2014: weekly assessments were done 4 out of 5 weeks
-February 2014: weekly assessments were done 3 out of 4 weeks
-March 2014: weekly assessments were done 2 out of 4 weeks
-April 2014: weekly assessments were done 1 out of 4 weeks
-May 2014: weekly assessments were done 2 out of 5 weeks

As such, Resident #005 who was exhibiting altered skin integrity such as a pressure ulcer to a specific area (stage x to stage 3) was not reassessed at least weekly by a member of the registered nursing staff when it was clinically indicated. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that Resident #003 and Resident #005 who are exhibiting altered skin integrity receive a skin assessment by a member of the registered nursing staff upon any return from hospital and reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c. 8, s. 76. (4) in that the home did not ensure that all staff have received retraining annually relating to the following: the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protection.

On August 8, 2014, Inspector #126 discussed with the Nurse Educator, staff #S121, who indicated that in 2013 Health and Safety week up until now there was no education related to abuse, reporting and whistle-blowing protection. She indicated that a quiz was given to staff related to Residents' Bill of Rights and other topics such as privacy, personal belongings, code drills. RPN #S121 worked in the capacity of the Nurse Educator for the past year and a half and since she was in the position she had not given annual education to staff related to abuse, reporting and whistle-blowing. The Education Binder was reviewed for 2013 and 2014 and no education on abuse was given to staff during that period.

Discussion with the Assistant Administrator indicated that training was given to new employees as part of the orientation program related to Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports. One new employee record was reviewed by Inspector #126 and it was noted that education was provided and staff signed a form to confirm that it was done. The document signed by the employee was signed in the summer of 2013. The office manager indicated that she had not done any annual education related to the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protections.

Discussion with the Administrator, indicated to Inspector #126 that in the past the mandatory education was given on a yearly basis and that the home required staff to sign a document to confirm they attended the mandatory annual education. Several staff files were reviewed by the Administrator and Inspector #126 and it was noted that the the mandatory annual education was done for 2011-2012 but not for 2013.

Discussion with Staff #S111 and #S126 indicated that they did not remember having education related to the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protection on an annual basis. [s. 76. (4)]

Additional Required Actions:

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

WN #5: 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. Reg 79/10 s. 130 (1) in that the licensee did not ensure that all areas where drugs are stored are kept locked at all time when not in use.

The Medication Room was located on the second floor and referred to as the Nursing Room/Salle des infirmières. This room contained all Government Stock medications, discarded medications, residents' charts, the Treatment Cart, a computer, resource manuals such as Policies and Procedures.

The door to the Medication Room was observed unlocked on July 30 and August 7, 2014.

On August 7, 2014, it was observed by Inspector #126 that the home kept the Government stocks such as Novasen, Acetaminophen, Senokot, Diphenhydramine, Bisacodyl, Dimenhydrinate, Vitamin C, Lactulose syrup, Advair pump in an unlocked cupboard in that room.

Also, the home kept the discarded/discontinued medications in a basket in an unlocked cupboard. [s. 130. 1.]

2. The licensee has failed to comply with O.Reg 79/10 s. 130 (2)(i) (ii) in that the home did not ensure that steps are taken to ensure the security of the drug supply and that access to these areas shall be restricted to persons who may dispense, prescribe or administer drugs in the home, and the administrator.

On July 29, 2014 Inspector #547 observed the Environmental Manager unlocking the Nursing Room/Salle des infirmières on the second floor. No registered staff or the Administrator were in this room at the same time as the Environmental Manager. This room had 2 non-locking cupboards containing medications for resident use in the home.

On July 30, 2014 Inspector #547 interviewed the home's Physiotherapy Assistant #S110 who was in this same Nursing Room/Salle des infirmières alone, with no other registered staff or administrator in this room who indicated that she had access to this room as it was the location for the residents' physical charts. This room had two non-locking cupboards containing medications for residents use in the home. (547)

On August 7, 2014, RN #S111 indicated to Inspector #126 that the medication room was used by team members (physiotherapy, dietary, housekeeping). The housekeeping staff came in that room to do the cleaning and the nursing staff did not stay in that room while she did the cleaning.

Physiotherapy assistant #S110 was observed using that room to finish the documentations on the residents and no registered nursing staff was in that room. Staff that were using that medication room for either charting or cleaning were instructed to close the door and make sure it was locked upon leaving. [s. 130. 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that steps are taken to ensure the security of the drug supply is kept locked at all times, when not in use and access to these areas shall be restricted to persons who may dispense, prescribe or administer drugs in the home, and the administrator, to be implemented voluntarily.

WN #6: 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 has failed to comply with LTCHA, 2007, S.O.2007, c. 8, s. 3. (1) 11. iv in that the licensee did not ensure that residents 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.

On August 7, 2014, Inspector #126 observed the medication pass of RPN #S112. It was observed that RPN #S112 was discarding the medication pouches with the name of the resident, the medication and dosage in a garbage can attached to the medication cart. She indicated that when the garbage bag was full, the content was thrown in the regular garbage.

Discussion with the DOC and Day RN on July 31, 2014 and they indicated that the medications with personal health information was thrown in the regular garbage. [s. 3. (1) 11. iv.]

WN #7: 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.O. 2007, c.8, s. 15 (2) (a) in that the licensee did not ensure that the furnishings and equipment are kept clean and sanitary.

Upon review of the home's policies regarding: Housekeeping Cleaning Duties and PSW/HCA Cleaning Duties, the expected outcome was documented as follows: "a clean and pleasant environment for residents to live in, staff to work in and for visitors".

In a review of the home's cleaning policies and procedures provided by the Environmental Manager and Assistant Administrator, the following were noted:
Housekeeper Daily Cleaning Schedule
• "the housekeeping aide is responsible in cleaning residents' washroom on a daily basis"
PSW/HCA Cleaning Duties
• "the PSW/HCA are responsible for the general cleanliness of the Resident environment and personal effects as part of their care"

On July 29, 2014 Inspector #547 observed 3 residents' shared washrooms noting the following:
Room 100
• brown matter stuck to base of toilet, and brown debris to the perimeter of toilet

Room 101
• brown matter covering the screws on the legs of the white metal commode

Room 200
• dark dried matter to the inside of the bubble raised toilet seat installed on toilet
• dark dried matter to the inside of the toilet, on the toilet tank and on top of the toilet tank

During an interview with Housekeeping Aide #S127 on August 7, 2014, she indicated that it was her responsibility to clean the residents' washroom including the toilets using Fantastik; adding that the cleaning of the raised toilet seats and commodes were the responsibility of the PSWs.

During an interview with PSW #S128 on August 8, 2014, she indicated that PSWs were expected to follow the Day Cleaning Schedule, for example cleaning the desk areas, the front rooms, the tubs, lift chairs and accessories in between baths and residents' mattress and boards when changing linen. She indicated that it was the responsibility of the housekeeper to clean the toilets, commodes and raised toilet seats. She indicated that if she noticed soiled areas, she would use Virox and wipe the soiled area.

On August 7, 2014 at 14:30 Inspector #545 observed 3 residents' shared washrooms noting the following:

Room 100
• one wheeled commode set between sink and toilet filled with feces and urine, cover was closed
• one stationary commode set over the toilet filled with feces and urine
• brown matter stuck to base of toilet, and brown debris to the perimeter of toilet
• large dried yellow stain on the toilet rim closer to the water tank

Room 101
• brown matter covering one screw on the front leg of the white metal stationary commode, all other screws were heavily rusted
• one long dark streak in toilet bowl

Room 200
• dark dried matter to the inside of the bubble raised toilet seat installed on toilet
• dark dried matter to the inside of the toilet, on the toilet tank and on top of the toilet tank
• large dried yellow stain on the toilet rim closer to the water tank

During an interview with the Environmental Manager on August 7, 2014 he indicated that it was the responsibility of the housekeeping aide to clean and disinfect all toilets on a daily basis. When observed with Inspector #545, rooms 100, 101 and 200 he indicated that it was unacceptable for the toilets, raised toilet seats and commodes to be soiled as observed. He immediately asked the housekeeping aide to clean the toilet and the raised toilet seat in room 200. [s. 15. (2) (a)]

WN #8: 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.Reg 79/10 s. 37 (1) (a) in that the home did not ensure that each resident of the home had his or her personal items aids,(a) labelled within 48 hours of admission and of acquiring, in the case of new items.

During the course of the Resident Quality Inspection, Inspectors #545, #547, and #592 observed unlabelled personal care items in residents' rooms, bathrooms and shared bathrooms throughout the home.

Between July 28 and August 1, 2014; the above inspectors observed the following unlabelled personal care items:
-Room 101 (shared bathroom): 1 tooth brush, 1 tube of toothpaste on the counter of the sink
-Room 104 (shared bathroom): 1 toothbrush
-1 white plastic cart on wheels with several drawers placed at the entrance of spa/tub room (1st floor) on July 28, 2014 with the following unlabelled items: 2 hair brushes, 1 jar facial cream (St-Eves), 3 combs, 2 large nail clippers, 1 jar vitarub, two bar of soap in a green plastic container, 1 metal nail file
-1 white plastic cart on wheels with several drawers used for all 3 tub/spa rooms (observed in tub/spa room, 2nd floor) on August 1, 2014: 3 hair brushes with hair in the bristles, 3 nail clippers, 1 nail scissor and 2 used disposal nail files

On July 28, 2014 during an interview with PSW #S100, she indicated that the cart was stored on the second floor linen closet at the end of her shift and that the white plastic cart on wheels was used by all PSWs for all Residents receiving baths. She indicated that she brought the white plastic cart on wheels with her in the tub/spa rooms on the 1st, 2nd and 3rd floors. She indicated that the hair brushes (unlabelled) were used for all residents requiring hair brushing following their bath.

On July 30, 2014 during an interview with PSW #S101, she indicated that staff utilized the same nail scissors and nail files located in the plastic white cart on wheels, and that the staff were expected to clean these scissors and files before and after each resident use with an alcohol wipe.

On August 1, 2014 during an interview with PSW #S102, she showed Inspector #592 the content of the drawers and indicated that the unlabelled brushes, files, nail clippers and scissors, were used for all residents and that they were cleaned after each use with alcohol.

During interviews with PSW #S115 and PSW #S103 they indicated that the unlabelled hair brushes should not be kept in the white plastic cart on wheels. They indicated that these items should have been labelled. The PSWs indicated that most residents had their own hair brushes or combs which were kept in their room therefore the brushes and combs in the white plastic cart on wheels were not used. PSW #S103 added that they would use the unlabelled brushes and combs in the cart, if residents didn't own any but that she would be expected to clean them with Virox. [s. 37. (1) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 41 in that the home did not ensure that the resident's desired bedtime and rest routine was supported and individualized to promote comfort, rest and sleep.

On August 7, 2014 at 08:15 Inspector #545 observed Resident #015 dressed in street clothes, resting in his/her bed under the covers. When asked if he/she had eaten breakfast, Resident #015 indicated that staff had gotten him/her up before 07:00 for breakfast and that he/she was very tired. Resident indicated that he/she had never been an early riser, and always got up for breakfast after 09:00 and enjoyed tea and toast.

In a review of Resident #015's most recent plan of care it was indicated that Resident #015 desired to sleep in instead of coming down to breakfast and that Resident had permission to go to the 2nd sitting if wanted to sleep longer in the morning.

During an interview with PSW #S120, she indicated that she got Resident #015 before 07:00 as Resident was scheduled for 1st breakfast; PSW indicated that she was aware that Resident had permission to get up later and go to the 2nd breakfast but PSW still tried to convince Resident to get up for 1st breakfast.

During an interview with RPN #S112, she indicated that staff usually got Resident #015 up for breakfast by 07:00. RPN indicated she was aware that Resident #015 liked to sleep in the morning but she encouraged staff to get Resident up because she didn't want Resident #015 to stay in bed due to a mood disorder and lower extremity edema. RPN indicated that maybe twice weekly, she allowed PSW to let Resident #015 sleep in the morning and have breakfast later. RPN #S112 added that staff were very busy between and after breakfast with toileting and baths and may not have time to provide assistance with dressing to Resident #015.

During an interview with the RAI Coordinator/Acting DOC on August 7, 2014 she indicated that Resident #015 did not like to get up in the morning, and that family had indicated upon admission that Resident was not an early riser. She indicated that staff should be respecting Resident #015's wish by letting him/her sleep in the morning and having tea and toast at second sitting breakfast. [s. 41.]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 57 (2) in that the licensee did not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

In a review of the Residents' Council minutes for 2014, the following concerns were documented:

July 23, 2014
• Nursing Staff noise levels have increased again at 06:00 report in the 2nd floor lounge

June 18, 2014
• If the urns by the gazebo are not being used, could they be put away, as they hold water which breeds mosquitoes--> urns to be stored
• Residents want more bologna sandwiches and Kraft Dinner on the menu

April 9, 2014
• Staff coming on at 6am and 10pm still very noisy in the lounge. Chairs scraping the floor
• Residents being put in pajamas (2nd floor) at 6pm and go to bed too early for lack of anything to do then awaken at 8pm for collation. Some residents have difficulty falling back to sleep
• Some residents feel they are not welcome in the Administration office

March 12, 2014
• Complaints that the shift coming on at 10:00pm are noisy when residents are asleep
• Residents on the 2nd floor would like to play cards longer on Tuesday Activity night but second feeding is interfering with this activity
• Residents would like different movies to watch

During an interview with a member of the Residents' Council, Resident #021 on August 5, 2014, it was indicated that the Administrator did not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

On August 5, 2014, during an interview with the Administrator she indicated that a response in writing within 10 days was not provided upon receiving Residents' Council advice related to concerns or recommendations. [s. 57. (2)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 59 (7) (b) in that the licensee did not convene semi-annual meetings to advice residents' families and persons of importance to residents of their right to establish a Family Council, when there is no Family Council established in the home.

During an interview with the Acting Director of Activity on August 1, 2014, she indicated that the home did not have a Family Council.

On August 1, 2014 during an interview with the Administrator, she stated that the home included a note in the Resident/Family Newsletters of August 2013 and July 2014, seeking members for their wish to establish a Family Council. The Administrator indicated that the home did not convene semi-annual meetings to advice residents' families and persons of importance to residents of their right to establish a Family Council. [s. 59. (7) (b)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 67 in that the licensee did not consult regularly with the Residents' Council, and in any case, at least every three months.

During an interview with a Resident #021, a member of the Residents' Council on August 5, 2014, it was indicated that she/he didn't think that the Administrator consulted regularly with the Residents' Council.

On August 5, 2014 in discussion with the Administrator, she indicated that she read the monthly minutes of the Residents' Council but did not consult with the Residents' Council, and in any case, at least every three months. [s. 67.]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 85 (3) in that the licensee did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

On August 5, 2014 during an interview with Resident #021, a member of the Residents' Council, it was indicated that the Administrator did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

During an interview with the Administrator, she indicated that the 2014 survey was sent early January 2014 to POA and responsible parties of the home's residents. She indicated that the home did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

2. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 85 (4) (a) in that the licensee did not document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

On August 5, 2014 during an interview with Resident #021, a member of the Residents' Council, it was indicated that she/he remembered completing the satisfaction survey but didn't remember the Administrator sharing the results in order to seek the advice of the Council about the survey.

During an interview with the Administrator on August 5, 2014, she indicated the 2014 satisfaction survey was posted on the Continuous Quality Improvement Board near her office in the basement but that it was not made available to the Residents' Council in order to seek their advice about the survey. [s. 85. (4) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (1) Every licensee of a long-term care home shall ensure that housekeeping services are provided seven days per week. O. Reg. 79/10, s. 87 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 87 (1) in that the home did not provide housekeeping services 7 days per week.

In an interview with Housekeeping Aide #S127 on August 7, 2014, she indicated that housekeeping services were not provided 7 days per week, adding that the staff worked on a rotation whereby housekeeping services were offered 10 out of 14 days. She indicated that the housekeeping aide worked one weekend every second weekend.

On August 7, 2014 in an interview with the Environmental Manager, he indicated that in 2009 due to cut in budget, the home initiated a rotation for housekeeping services, providing daily service during the week but only every second weekend. He indicated that the home had one full-time housekeeping aide and that the laundry aide covered for the housekeeping aide when on holidays.

During an interview with the Assistant Administrator on August 8, 2014 she indicated that the home provided housekeeping services 12 out of 14 days, indicating that she notified the Environmental Manager when the housekeeping aide was off during the week so that he would at least empty the garbage on all units. She went on to explain the housekeeping service schedule:

• 1 Housekeeping aide worked 10 out of 14 days; off Sat-Sun, worked Mon-Tue-Wed, off Thurs, worked Fri-Sat-Sun, off Mon, worked Tues-Wed-Thur-Fri
• 1 Environmental Manager worked 10 out of 14 days; Monday to Friday

On August 8, 2014, the Administrator indicated that the home did not provide housekeeping services seven days per week at the moment but would immediately implement daily housekeeping services as per legislation. [s. 87. (1)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 91 in that the home did not ensure that all hazardous substances are labelled properly and kept inaccessible to residents at all times.

Over the course of this inspection, the door to the Spa/Tub room on the 1st floor was observed open at all times, by all inspectors. A large cupboard containing various care products and cleaning products were located inside the Spa/Tub room. On August 7, 2014, the door to the cupboard was observed opened and the following hazardous products were observed:
-Disinfectant Cleanser IV , disinfectant/virucide , 3L bottle container with a small amount and no lid
-Alcohol 70%, 1 bottle

During an interview with PSW #S104 on August 7, 2014, she indicated that the cupboard should have been locked as hazardous products were kept in the cupboard, and proceeded to locking the cupboard.

During an interview with the Environmental Manager on August 8, 2014 he indicated that both products were hazardous as per the Material Safety Data Sheet (MSDS):
-Disinfectant Cleanser IV , disinfectant/virucide: corrosive and poison
-Alcohol 70%: irritant in case of contact to skin, eyes and if ingested

The Environmental Manager indicated that the door to the cupboard in the Spa/Tub room should be locked at all times as hazardous products were kept in the cupboard. He indicated that all staff had a key to access the cupboard and were instructed to keep it locked at all times. [s. 91.]

WN #16: 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. Reg. 129. (1) (a) ii, in that the licensee did not ensure that the drugs are stored in an area that is secure and locked.

On July 28, 2014 at 9:30 Inspector #592 observed a medication cart unlocked, unattended on the main floor (basement) in front of the administration's office and near the Dining Room where residents were provided their meals.

Over the course of 45 minutes, the medication cart was observed unlocked and unattended, until a registered staff came by at 10:15 and removed the cart. [s. 129. (1) (a) (ii)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 136 (6) in that the licensee did not ensure that when a drug is destroyed, the drug is altered or denatured to such an extent that is consumption is rendered impossible or improbable.

The Disposal of Surplus Prescribed Drugs policy was reviewed by Inspector #126. It was noted in the policy that "surplus prescribed drugs are sent, picked up, by Daniel Sharpsmart & Pharmasmart Waste as established by Classic Pharmacy".

The Medication Room was located on the second floor and referred to as the Nursing Room/Salle des infirmières. This room contained all Government Stock medications, discarded medications, residents’ charts, the Treatment Cart, a computer, resource manuals such as Policies and Procedures.

Discussion held with the Director of Care and RN #S111, indicated that the discontinued or unused medications were put in a basket that was kept in a cupboard in the medication room on the second floor. These medications were reviewed by 2 night staff then were put in a container that was picked up by Daniel Sharpsmart & Pharmasmart Waste and were to be destroyed off site.

Inspector #126 observed several drugs (pills, syrup, injectable, eyes drop) in a white basket in a cupboard in the medication room on the second floor. Also observed were discarded drugs, not altered or denatured, kept in a small yellow container with a cover named Biohazard Waste Container. [s. 136. (6)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 228.
Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 228 (3) in that the home did not ensure that the improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents are communicated to the Residents' Council.

During an interview with Resident #021, a member of the Residents' Council, it was indicated that he/she didn't think improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents were communicated to the Residents' Council.

On August 5, 2014 the Administrator indicated that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents had not been communicated to the Residents' Council in the past two years. [s. 228. 3.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 131. (3)	CO #901	2014_284545_0020	545

Issued on this 15th day of August, 2014

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Aug 8, 14, 2014	2014_284545_0020	O-000717-14	Resident Quality Inspection

Licensee/Titulaire de permis

TAMINAGI INC.
05 Loiselle Street, CP Box 2132, Embrun, ON, K0A-1W1

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

SARSFIELD COLONIAL HOME
2861 Colonial Road, P.O. Box 130, Sarsfield, ON, K0A-3E0

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

ANGELE ALBERT-RITCHIE (545), LINDA HARKINS (126), LISA KLUKE (547), LYNE DUCHESNE (117), MELANIE SARRAZIN (592)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): July 28-29-30-31, August 1-5-6-7-8, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Administrator, Nutrition Manager/Acting Activity Director, Environmental Manager, RAI Coordinator/Acting Director of Care, Registered Dietitian, Pharmacist, several Registered Nurses (RN), several Registered Practical Nurses (RPN), one Physiotherapy Assistant, one Housekeeping Assistant, one Dietary Aide, one member of the Residents' Council, family members and residents.

During the course of the inspection, the inspector(s) conducted a tour of all resident care areas, observed Residents' rooms, observed Resident common areas, observed a medication administration pass and medication storage areas, observed two meal services, reviewed resident health records, staff schedules, relevant home several policies, Residents' Council minutes and observed delivery of Resident care and services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Training and Orientation

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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

The licensee has failed to comply with O.Reg 79/10 s. 131 (3), subject to subsection 4.1 and s. 131 (8) (b) in that the home did not ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

In accordance with O.Reg 79/10 s. 131 (4.1):
A member of the registered nursing staff may permit a nursing student to administer drugs to residents if,

(a) the licensee has verified with the university or college that offers the nursing educational program in which the nursing student is enrolled that the nursing student has received education or training about the administration of drugs as part of the program;

(b) the nursing student has been trained by a member of the registered nursing staff in the written policies and protocols for the medication management system referred to in subsection 114 (2);

(c) the member of the registered nursing staff who is permitting the administration is satisfied that the nursing student can safely administer drugs; and

(d) the nursing student who administers the drugs does so under the supervision of the member of the registered nursing staff. O. Reg. 218/13, s. 1 (2).

And in accordance with O.Reg 79/10 s. 131 (8), in this section, the "nursing student" means a person,

(a) who is enrolled in an educational program, the successful completion of which meets the educational requirements for the issuance of a certificate of registration as a registered nurse or registered practical nurse as set out in the regulations made under the Nursing Act, 1991, and

(b) who is working in the long-term care home as part of the clinical placement requirement of the educational program pursuant to an agreement between the licensee and the university or college that offers the educational program. ("étudiante infirmière ou étudiant infirmier") O. Reg. 79/10, s. 131 (8); O. Reg. 218/13, s. 1 (3).

During the course of the Resident Quality Inspection, Staff #S117 was observed on several day shifts providing care and services to Residents in the home in the capacity of a Personal Support Worker (PSW).

In reviewing staffing schedule for the period of July 19 to August 15, 2014, it was

noted that Staff #S117 was scheduled as Registered Practical Nurse on the following day shifts:
• July 25 & 30, 2014
• August 2, 3, 8 and 13 2014

This home provides care and services to 46 residents on three floors. The registered practical nurse during the day is responsible to administer drugs to all 46 residents, as prescribed.

On August 8, 2014 at 08:20, Inspector #545 observed Staff #S117 administering oral drugs to residents on the 3rd floor. When asked if she was a registered practical nurse (RPN) or a registered nurse (RN), Staff #S117 indicated that she was not a RPN or RN. Staff #S117 indicated she was a nursing student going back to university in September 2014. Staff #S117 indicated that the DOC was aware that she did not have a license to practice as RN or RPN, and that the DOC allowed her to practice as a Registered Practical Nurse, as well as PSW.

On August 8, 2014 at 08:45, during an interview with the RAI Coordinator/Acting DOC, she indicated that she thought Staff #S117 had a temporary license to practice as RPN. In discussion with the Assistant Administrator (Office Manager), she indicated that Staff #S117 had no RPN or RN license, and was not working in this long term care home as part of a clinical placement. The Assistant Administrator added that the DOC had given her permission to schedule Staff #S117 as RPN on all three floors of the home.

On August 8, 2014 at 08:50, during a phone interview with the Administrator, she indicated to Inspector #126 that she was aware that Staff #S117 was not a RPN and that the home was scheduling this staff as RPN. The Administrator indicated that she thought it was acceptable to schedule Staff #S117 in the capacity of RPN being that she was going back to University in September 2014 to finish the nursing program.

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 8 (1) (b) in that the home did not ensure that the any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

As per O.Reg 79/10 s. 48 (1) 2, every licensee of a long-term care home shall ensure that the following interdisciplinary programs is developed and implemented in the home: Skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

The Home's Skin Care Policy (revised May 28, 2013) and Skin/Wound Protocol (revised May 27, 2013) were reviewed by Inspector #545 and Inspector #126 and the following directions were found:

Skin Care Policy: Policy for routine skin assessment and reporting:
•Item 3, under the section Procedure, it was indicated that "If skin condition, sores, ulcers…not improving, the RN/RPN will assure physician is notified either by phone or his next visit by writing comments on 'Weekly Physician visit' form"

Skin/Wound Protocol:
•Item 10 under Procedure indicated: "A photo must be taken for all wounds stage 3, 4 or X initially, monthly and when necessary and kept in "Treatment and Observation Record" and TARS if applicable."
•Item 14 under the section Procedure indicated: "If a Resident has a stage 3 or more; the RN/RPN must notify the DOC and discuss action plan. E.T. can be called for consultation but no longer covered by HIN. If stage 2, treatment will be discussed with physician for appropriate treatment."
•Item 1 under section Procedure for Clean Dressing Change indicated: "Check

physician order for current, correct treatment"
•Item 16 under section Procedure for Clean Dressing Change indicated: "Apply medication as per order of physician and dressing as per recommendation of physician."

Residents #003 and #005 were assessed as having Stage 3 pressure ulcers which are defined as:
A full thickness of skin is lost, exposing the subcutaneous tissues – presents as a deep crater with or without undermining adjacent tissue.

Resident #005 was assessed as having a stage 3 pressure ulcer to a specific area for a period of one year.

Inspector #545 reviewed Resident #005's most recent plan of care. It was indicated under Skin Integrity to do "dressing as per doctor's orders". The only order found on the most recent Physician Medication Review was "Skin Protocol".

No picture of the Stage 3 pressure ulcer of the specific area was found in the "Treatment and Observation Record" and TARS for Resident #005, as per RAI Coordinator/Acting Director of Care.

During an interview with RN #S111 on August 1, 2014 she indicated that she never requested orders for Resident #005's Stage 3 pressure ulcer, added that various treatments were initially tried then by mid-October 2013 an antimicrobial packing was initiated. RN #S111 indicated that 8 months later the treatment was changed to a antimicrobial cream. The RN indicated that the antimicrobial creams were available in the home and that she didn't think she required to consult with the physician for treatment of a Stage 3 pressure ulcer; that the doctor trusted the registered staff with skin care protocols. RN #111 indicated that she was not a Nurse Practitioner or an Enterostomal Therapy (ET) nurse.

On August 5, 2014 during an interview with the RAI Coordinator/Acting DOC, she indicated that the ET nurse would have been consulted by telephone or email and that a photo of the wound would probably have been sent in October 2013 regarding Resident #005's stage 3 pressure ulcer but was unable to find any documentation or photo. She indicated that it was the home's expectation that the ET nurse's recommendations be discussed with the physician and co-signed by this one. [s. 8. (1) (a),s. 8. (1) (b)]

2. Resident #003 had a stage 3 pressure ulcer to a specific area.

During a discussion with RN #S111, she indicated to Inspector #126 that the RAI Coordinator sent a picture (via email) of the pressure ulcer to the Enterostomal Therapy (ET) nurse on a specific date in July 2014 and that the ET nurse had recommended a specific treatment which was started and documented by registered staff on the "Treatment and Observation Record".

On July 31, 2014, the RN #S111 indicated that the home had not consulted and obtained an order from the physician to administer the treatment. A telephone order was obtained on August 1, 2014 for the specific treatment. (126) [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place for Skin and Wound Care Program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg s. 50.(2) (a)(ii) in that the licensee did not ensure that resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

Resident #003 was admitted to the hospital on a specific date in July 2014 and returned to the home three days later. Resident #003 had Stage 3 pressure ulcer to a specific area prior to discharge to the hospital. Resident #003's dressing was changed the day after returning from hospital and no documentation was completed related to the skin assessment as per the home's policy.

On August 5, 2014, discussion with RN #S111, indicated that Resident #003's skin assessment was still not completed as required by the policy as of today. [s. 50. (2) (a) (ii)]

2. The licensee has failed to comply with O.Reg 79/10 s .50 (2) (b) (iv) in that the home did not ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #005's assessment prior to hospitalization one year ago demonstrated that he/she was totally dependent for all activities of daily living with severe cognitive impairment. As per a review of the doctor's orders, it was documented that upon the return from hospital, palliative care was initiated.

As per a review of the "Skin Care Management - Treatment and Observations Record", it was documented that Resident #005 returned from hospital one year ago with an unbroken blood blister to a specific area.

In the last year, the pressure ulcer's healing process was documented as follows on the "Skin Care Management - Treatment and Observations Record":
-A specific date in October 2013: stage 3 ulcer
-A specific date in November 2013: stage X ulcer
-A specific date in December 2013: foul drainage, swab taken and sent to lab
-A specific date in May 2014: stage 2 ulcer
-A specific date in June 2014: increased in size
-14 days later in June 2014: foul drainage
-12 days later in June 2014: swab taken and sent to the lab
-2 days later in July 2014: stage X ulcer
-A specific date in July 2014: stage 3 ulcer

During an interview with RN #S111, she confirmed that weekly skin assessments were not done weekly between Resident #005's return from hospital one year ago and the end of July 2014 when Resident #005 was exhibiting a pressure ulcer to a specific area that was not healing:
-September 2013: weekly assessments were done 1 out of 4 weeks
-October 2013: weekly assessments were done 3 out of 4 weeks
-November 2013: weekly assessments were done 1 out of 4 weeks
-January 2014: weekly assessments were done 4 out of 5 weeks
-February 2014: weekly assessments were done 3 out of 4 weeks
-March 2014: weekly assessments were done 2 out of 4 weeks
-April 2014: weekly assessments were done 1 out of 4 weeks
-May 2014: weekly assessments were done 2 out of 5 weeks

As such, Resident #005 who was exhibiting altered skin integrity such as a pressure ulcer to a specific area (stage x to stage 3) was not reassessed at least weekly by a member of the registered nursing staff when it was clinically indicated. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that Resident #003 and Resident #005 who are exhibiting altered skin integrity receive a skin assessment by a member of the registered nursing staff upon any return from hospital and reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c. 8, s. 76. (4) in that the home did not ensure that all staff have received retraining annually relating to the following: the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protection.

On August 8, 2014, Inspector #126 discussed with the Nurse Educator, staff #S121, who indicated that in 2013 Health and Safety week up until now there was no education related to abuse, reporting and whistle-blowing protection. She indicated that a quiz was given to staff related to Residents' Bill of Rights and other topics such as privacy, personal belongings, code drills. RPN #S121 worked in the capacity of the Nurse Educator for the past year and a half and since she was in the position she had not given annual education to staff related to abuse, reporting and whistle-blowing. The Education Binder was reviewed for 2013 and 2014 and no education on abuse was given to staff during that period.

Discussion with the Assistant Administrator indicated that training was given to new employees as part of the orientation program related to Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports. One new employee record was reviewed by Inspector #126 and it was noted that education was provided and staff signed a form to confirm that it was done. The document signed by the employee was signed in the summer of 2013. The office manager indicated that she had not done any annual education related to the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protections.

Discussion with the Administrator, indicated to Inspector #126 that in the past the mandatory education was given on a yearly basis and that the home required staff to sign a document to confirm they attended the mandatory annual education. Several staff files were reviewed by the Administrator and Inspector #126 and it was noted that the the mandatory annual education was done for 2011-2012 but not for 2013.

Discussion with Staff #S111 and #S126 indicated that they did not remember having education related to the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protection on an annual basis. [s. 76. (4)]

Additional Required Actions:

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

WN #5: 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. Reg 79/10 s. 130 (1) in that the licensee did not ensure that all areas where drugs are stored are kept locked at all time when not in use.

The Medication Room was located on the second floor and referred to as the Nursing Room/Salle des infirmières. This room contained all Government Stock medications, discarded medications, residents' charts, the Treatment Cart, a computer, resource manuals such as Policies and Procedures.

The door to the Medication Room was observed unlocked on July 30 and August 7, 2014.

On August 7, 2014, it was observed by Inspector #126 that the home kept the Government stocks such as Novasen, Acetaminophen, Senokot, Diphenhydramine, Bisacodyl, Dimenhydrinate, Vitamin C, Lactulose syrup, Advair pump in an unlocked cupboard in that room.

Also, the home kept the discarded/discontinued medications in a basket in an unlocked cupboard. [s. 130. 1.]

2. The licensee has failed to comply with O.Reg 79/10 s. 130 (2)(i) (ii) in that the home did not ensure that steps are taken to ensure the security of the drug supply and that access to these areas shall be restricted to persons who may dispense, prescribe or administer drugs in the home, and the administrator.

On July 29, 2014 Inspector #547 observed the Environmental Manager unlocking the Nursing Room/Salle des infirmières on the second floor. No registered staff or the Administrator were in this room at the same time as the Environmental Manager. This room had 2 non-locking cupboards containing medications for resident use in the home.

On July 30, 2014 Inspector #547 interviewed the home's Physiotherapy Assistant #S110 who was in this same Nursing Room/Salle des infirmières alone, with no other registered staff or administrator in this room who indicated that she had access to this room as it was the location for the residents' physical charts. This room had two non-locking cupboards containing medications for residents use in the home. (547)

On August 7, 2014, RN #S111 indicated to Inspector #126 that the medication room was used by team members (physiotherapy, dietary, housekeeping). The housekeeping staff came in that room to do the cleaning and the nursing staff did not stay in that room while she did the cleaning.

Physiotherapy assistant #S110 was observed using that room to finish the documentations on the residents and no registered nursing staff was in that room. Staff that were using that medication room for either charting or cleaning were instructed to close the door and make sure it was locked upon leaving. [s. 130. 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that steps are taken to ensure the security of the drug supply is kept locked at all times, when not in use and access to these areas shall be restricted to persons who may dispense, prescribe or administer drugs in the home, and the administrator, to be implemented voluntarily.

WN #6: 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 has failed to comply with LTCHA, 2007, S.O.2007, c. 8, s. 3. (1) 11. iv in that the licensee did not ensure that residents 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.

On August 7, 2014, Inspector #126 observed the medication pass of RPN #S112. It was observed that RPN #S112 was discarding the medication pouches with the name of the resident, the medication and dosage in a garbage can attached to the medication cart. She indicated that when the garbage bag was full, the content was thrown in the regular garbage.

Discussion with the DOC and Day RN on July 31, 2014 and they indicated that the medications with personal health information was thrown in the regular garbage. [s. 3. (1) 11. iv.]

WN #7: 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.O. 2007, c.8, s. 15 (2) (a) in that the licensee did not ensure that the furnishings and equipment are kept clean and sanitary.

Upon review of the home's policies regarding: Housekeeping Cleaning Duties and PSW/HCA Cleaning Duties, the expected outcome was documented as follows: "a clean and pleasant environment for residents to live in, staff to work in and for visitors".

In a review of the home's cleaning policies and procedures provided by the Environmental Manager and Assistant Administrator, the following were noted:
Housekeeper Daily Cleaning Schedule
• "the housekeeping aide is responsible in cleaning residents' washroom on a daily basis"
PSW/HCA Cleaning Duties
• "the PSW/HCA are responsible for the general cleanliness of the Resident environment and personal effects as part of their care"

On July 29, 2014 Inspector #547 observed 3 residents' shared washrooms noting the following:
Room 100
• brown matter stuck to base of toilet, and brown debris to the perimeter of toilet

Room 101
• brown matter covering the screws on the legs of the white metal commode

Room 200
• dark dried matter to the inside of the bubble raised toilet seat installed on toilet
• dark dried matter to the inside of the toilet, on the toilet tank and on top of the toilet tank

During an interview with Housekeeping Aide #S127 on August 7, 2014, she indicated that it was her responsibility to clean the residents' washroom including the toilets using Fantastik; adding that the cleaning of the raised toilet seats and commodes were the responsibility of the PSWs.

During an interview with PSW #S128 on August 8, 2014, she indicated that PSWs were expected to follow the Day Cleaning Schedule, for example cleaning the desk areas, the front rooms, the tubs, lift chairs and accessories in between baths and residents' mattress and boards when changing linen. She indicated that it was the responsibility of the housekeeper to clean the toilets, commodes and raised toilet seats. She indicated that if she noticed soiled areas, she would use Virox and wipe the soiled area.

On August 7, 2014 at 14:30 Inspector #545 observed 3 residents' shared washrooms noting the following:

Room 100
• one wheeled commode set between sink and toilet filled with feces and urine, cover was closed
• one stationary commode set over the toilet filled with feces and urine
• brown matter stuck to base of toilet, and brown debris to the perimeter of toilet
• large dried yellow stain on the toilet rim closer to the water tank

Room 101
• brown matter covering one screw on the front leg of the white metal stationary commode, all other screws were heavily rusted
• one long dark streak in toilet bowl

Room 200
• dark dried matter to the inside of the bubble raised toilet seat installed on toilet
• dark dried matter to the inside of the toilet, on the toilet tank and on top of the toilet tank
• large dried yellow stain on the toilet rim closer to the water tank

During an interview with the Environmental Manager on August 7, 2014 he indicated that it was the responsibility of the housekeeping aide to clean and disinfect all toilets on a daily basis. When observed with Inspector #545, rooms 100, 101 and 200 he indicated that it was unacceptable for the toilets, raised toilet seats and commodes to be soiled as observed. He immediately asked the housekeeping aide to clean the toilet and the raised toilet seat in room 200. [s. 15. (2) (a)]

WN #8: 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.Reg 79/10 s. 37 (1) (a) in that the home did not ensure that each resident of the home had his or her personal items aids,(a) labelled within 48 hours of admission and of acquiring, in the case of new items.

During the course of the Resident Quality Inspection, Inspectors #545, #547, and #592 observed unlabelled personal care items in residents' rooms, bathrooms and shared bathrooms throughout the home.

Between July 28 and August 1, 2014; the above inspectors observed the following unlabelled personal care items:
-Room 101 (shared bathroom): 1 tooth brush, 1 tube of toothpaste on the counter of the sink
-Room 104 (shared bathroom): 1 toothbrush
-1 white plastic cart on wheels with several drawers placed at the entrance of spa/tub room (1st floor) on July 28, 2014 with the following unlabelled items: 2 hair brushes, 1 jar facial cream (St-Eves), 3 combs, 2 large nail clippers, 1 jar vitarub, two bar of soap in a green plastic container, 1 metal nail file
-1 white plastic cart on wheels with several drawers used for all 3 tub/spa rooms (observed in tub/spa room, 2nd floor) on August 1, 2014: 3 hair brushes with hair in the bristles, 3 nail clippers, 1 nail scissor and 2 used disposal nail files

On July 28, 2014 during an interview with PSW #S100, she indicated that the cart was stored on the second floor linen closet at the end of her shift and that the white plastic cart on wheels was used by all PSWs for all Residents receiving baths. She indicated that she brought the white plastic cart on wheels with her in the tub/spa rooms on the 1st, 2nd and 3rd floors. She indicated that the hair brushes (unlabelled) were used for all residents requiring hair brushing following their bath.

On July 30, 2014 during an interview with PSW #S101, she indicated that staff utilized the same nail scissors and nail files located in the plastic white cart on wheels, and that the staff were expected to clean these scissors and files before and after each resident use with an alcohol wipe.

On August 1, 2014 during an interview with PSW #S102, she showed Inspector #592 the content of the drawers and indicated that the unlabelled brushes, files, nail clippers and scissors, were used for all residents and that they were cleaned after each use with alcohol.

During interviews with PSW #S115 and PSW #S103 they indicated that the unlabelled hair brushes should not be kept in the white plastic cart on wheels. They indicated that these items should have been labelled. The PSWs indicated that most residents had their own hair brushes or combs which were kept in their room therefore the brushes and combs in the white plastic cart on wheels were not used. PSW #S103 added that they would use the unlabelled brushes and combs in the cart, if residents didn't own any but that she would be expected to clean them with Virox. [s. 37. (1) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 41 in that the home did not ensure that the resident's desired bedtime and rest routine was supported and individualized to promote comfort, rest and sleep.

On August 7, 2014 at 08:15 Inspector #545 observed Resident #015 dressed in street clothes, resting in his/her bed under the covers. When asked if he/she had eaten breakfast, Resident #015 indicated that staff had gotten him/her up before 07:00 for breakfast and that he/she was very tired. Resident indicated that he/she had never been an early riser, and always got up for breakfast after 09:00 and enjoyed tea and toast.

In a review of Resident #015's most recent plan of care it was indicated that Resident #015 desired to sleep in instead of coming down to breakfast and that Resident had permission to go to the 2nd sitting if wanted to sleep longer in the morning.

During an interview with PSW #S120, she indicated that she got Resident #015 before 07:00 as Resident was scheduled for 1st breakfast; PSW indicated that she was aware that Resident had permission to get up later and go to the 2nd breakfast but PSW still tried to convince Resident to get up for 1st breakfast.

During an interview with RPN #S112, she indicated that staff usually got Resident #015 up for breakfast by 07:00. RPN indicated she was aware that Resident #015 liked to sleep in the morning but she encouraged staff to get Resident up because she didn't want Resident #015 to stay in bed due to a mood disorder and lower extremity edema. RPN indicated that maybe twice weekly, she allowed PSW to let Resident #015 sleep in the morning and have breakfast later. RPN #S112 added that staff were very busy between and after breakfast with toileting and baths and may not have time to provide assistance with dressing to Resident #015.

During an interview with the RAI Coordinator/Acting DOC on August 7, 2014 she indicated that Resident #015 did not like to get up in the morning, and that family had indicated upon admission that Resident was not an early riser. She indicated that staff should be respecting Resident #015's wish by letting him/her sleep in the morning and having tea and toast at second sitting breakfast. [s. 41.]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 57 (2) in that the licensee did not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

In a review of the Residents' Council minutes for 2014, the following concerns were documented:

July 23, 2014
• Nursing Staff noise levels have increased again at 06:00 report in the 2nd floor lounge

June 18, 2014
• If the urns by the gazebo are not being used, could they be put away, as they hold water which breeds mosquitoes--> urns to be stored
• Residents want more bologna sandwiches and Kraft Dinner on the menu

April 9, 2014
• Staff coming on at 6am and 10pm still very noisy in the lounge. Chairs scraping the floor
• Residents being put in pajamas (2nd floor) at 6pm and go to bed too early for lack of anything to do then awaken at 8pm for collation. Some residents have difficulty falling back to sleep
• Some residents feel they are not welcome in the Administration office

March 12, 2014
• Complaints that the shift coming on at 10:00pm are noisy when residents are asleep
• Residents on the 2nd floor would like to play cards longer on Tuesday Activity night but second feeding is interfering with this activity
• Residents would like different movies to watch

During an interview with a member of the Residents' Council, Resident #021 on August 5, 2014, it was indicated that the Administrator did not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

On August 5, 2014, during an interview with the Administrator she indicated that a response in writing within 10 days was not provided upon receiving Residents' Council advice related to concerns or recommendations. [s. 57. (2)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 59 (7) (b) in that the licensee did not convene semi-annual meetings to advice residents' families and persons of importance to residents of their right to establish a Family Council, when there is no Family Council established in the home.

During an interview with the Acting Director of Activity on August 1, 2014, she indicated that the home did not have a Family Council.

On August 1, 2014 during an interview with the Administrator, she stated that the home included a note in the Resident/Family Newsletters of August 2013 and July 2014, seeking members for their wish to establish a Family Council. The Administrator indicated that the home did not convene semi-annual meetings to advice residents' families and persons of importance to residents of their right to establish a Family Council. [s. 59. (7) (b)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 67 in that the licensee did not consult regularly with the Residents' Council, and in any case, at least every three months.

During an interview with a Resident #021, a member of the Residents' Council on August 5, 2014, it was indicated that she/he didn't think that the Administrator consulted regularly with the Residents' Council.

On August 5, 2014 in discussion with the Administrator, she indicated that she read the monthly minutes of the Residents' Council but did not consult with the Residents' Council, and in any case, at least every three months. [s. 67.]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 85 (3) in that the licensee did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

On August 5, 2014 during an interview with Resident #021, a member of the Residents' Council, it was indicated that the Administrator did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

During an interview with the Administrator, she indicated that the 2014 survey was sent early January 2014 to POA and responsible parties of the home's residents. She indicated that the home did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

2. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 85 (4) (a) in that the licensee did not document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

On August 5, 2014 during an interview with Resident #021, a member of the Residents' Council, it was indicated that she/he remembered completing the satisfaction survey but didn't remember the Administrator sharing the results in order to seek the advice of the Council about the survey.

During an interview with the Administrator on August 5, 2014, she indicated the 2014 satisfaction survey was posted on the Continuous Quality Improvement Board near her office in the basement but that it was not made available to the Residents' Council in order to seek their advice about the survey. [s. 85. (4) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (1) Every licensee of a long-term care home shall ensure that housekeeping services are provided seven days per week. O. Reg. 79/10, s. 87 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 87 (1) in that the home did not provide housekeeping services 7 days per week.

In an interview with Housekeeping Aide #S127 on August 7, 2014, she indicated that housekeeping services were not provided 7 days per week, adding that the staff worked on a rotation whereby housekeeping services were offered 10 out of 14 days. She indicated that the housekeeping aide worked one weekend every second weekend.

On August 7, 2014 in an interview with the Environmental Manager, he indicated that in 2009 due to cut in budget, the home initiated a rotation for housekeeping services, providing daily service during the week but only every second weekend. He indicated that the home had one full-time housekeeping aide and that the laundry aide covered for the housekeeping aide when on holidays.

During an interview with the Assistant Administrator on August 8, 2014 she indicated that the home provided housekeeping services 12 out of 14 days, indicating that she notified the Environmental Manager when the housekeeping aide was off during the week so that he would at least empty the garbage on all units. She went on to explain the housekeeping service schedule:

• 1 Housekeeping aide worked 10 out of 14 days; off Sat-Sun, worked Mon-Tue-Wed, off Thurs, worked Fri-Sat-Sun, off Mon, worked Tues-Wed-Thur-Fri
• 1 Environmental Manager worked 10 out of 14 days; Monday to Friday

On August 8, 2014, the Administrator indicated that the home did not provide housekeeping services seven days per week at the moment but would immediately implement daily housekeeping services as per legislation. [s. 87. (1)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 91 in that the home did not ensure that all hazardous substances are labelled properly and kept inaccessible to residents at all times.

Over the course of this inspection, the door to the Spa/Tub room on the 1st floor was observed open at all times, by all inspectors. A large cupboard containing various care products and cleaning products were located inside the Spa/Tub room. On August 7, 2014, the door to the cupboard was observed opened and the following hazardous products were observed:
-Disinfectant Cleanser IV , disinfectant/virucide , 3L bottle container with a small amount and no lid
-Alcohol 70%, 1 bottle

During an interview with PSW #S104 on August 7, 2014, she indicated that the cupboard should have been locked as hazardous products were kept in the cupboard, and proceeded to locking the cupboard.

During an interview with the Environmental Manager on August 8, 2014 he indicated that both products were hazardous as per the Material Safety Data Sheet (MSDS):
-Disinfectant Cleanser IV , disinfectant/virucide: corrosive and poison
-Alcohol 70%: irritant in case of contact to skin, eyes and if ingested

The Environmental Manager indicated that the door to the cupboard in the Spa/Tub room should be locked at all times as hazardous products were kept in the cupboard. He indicated that all staff had a key to access the cupboard and were instructed to keep it locked at all times. [s. 91.]

WN #16: 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. Reg. 129. (1) (a) ii, in that the licensee did not ensure that the drugs are stored in an area that is secure and locked.

On July 28, 2014 at 9:30 Inspector #592 observed a medication cart unlocked, unattended on the main floor (basement) in front of the administration's office and near the Dining Room where residents were provided their meals.

Over the course of 45 minutes, the medication cart was observed unlocked and unattended, until a registered staff came by at 10:15 and removed the cart. [s. 129. (1) (a) (ii)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 136 (6) in that the licensee did not ensure that when a drug is destroyed, the drug is altered or denatured to such an extent that is consumption is rendered impossible or improbable.

The Disposal of Surplus Prescribed Drugs policy was reviewed by Inspector #126. It was noted in the policy that "surplus prescribed drugs are sent, picked up, by Daniel Sharpsmart & Pharmasmart Waste as established by Classic Pharmacy".

The Medication Room was located on the second floor and referred to as the Nursing Room/Salle des infirmières. This room contained all Government Stock medications, discarded medications, residents’ charts, the Treatment Cart, a computer, resource manuals such as Policies and Procedures.

Discussion held with the Director of Care and RN #S111, indicated that the discontinued or unused medications were put in a basket that was kept in a cupboard in the medication room on the second floor. These medications were reviewed by 2 night staff then were put in a container that was picked up by Daniel Sharpsmart & Pharmasmart Waste and were to be destroyed off site.

Inspector #126 observed several drugs (pills, syrup, injectable, eyes drop) in a white basket in a cupboard in the medication room on the second floor. Also observed were discarded drugs, not altered or denatured, kept in a small yellow container with a cover named Biohazard Waste Container. [s. 136. (6)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 228.
Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 228 (3) in that the home did not ensure that the improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents are communicated to the Residents' Council.

During an interview with Resident #021, a member of the Residents' Council, it was indicated that he/she didn't think improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents were communicated to the Residents' Council.

On August 5, 2014 the Administrator indicated that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents had not been communicated to the Residents' Council in the past two years. [s. 228. 3.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 131. (3)	CO #901	2014_284545_0020	545

Issued on this 15th day of August, 2014

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

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) :	ANGELE ALBERT-RITCHIE (545), LINDA HARKINS (126), LISA KLUKE (547), LYNE DUCHESNE (117), MELANIE SARRAZIN (592)
Inspection No. / No de l'inspection :	2014_284545_0020
Log No. / Registre no:	O-000717-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 8, 14, 2014
Licensee / Titulaire de permis :	TAMINAGI INC. 05 Loiselle Street, CP Box 2132, Embrun, ON, K0A-1W1
LTC Home / Foyer de SLD :	SARSFIELD COLONIAL HOME 2861 Colonial Road, P.O. Box 130, Sarsfield, ON, K0A-3E0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CHANTAL CRISPIN

To TAMINAGI INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Order / Ordre :

The licensee shall ensure that Staff #117 stops administering prescribed drugs immediately to all residents in this home.

Grounds / Motifs :

1. The licensee has failed to comply with O.Reg 79/10 s. 131 (3), subject to subsection 4.1 and s. 131 (8) (b) in that the home did not ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

In accordance with O.Reg 79/10 s. 131 (4.1):
A member of the registered nursing staff may permit a nursing student to administer drugs to residents if,

(a) the licensee has verified with the university or college that offers the nursing educational program in which the nursing student is enrolled that the nursing student has received education or training about the administration of drugs as part of the program;

(b) the nursing student has been trained by a member of the registered nursing staff in the written policies and protocols for the medication management system referred to in subsection 114 (2);

(c) the member of the registered nursing staff who is permitting the administration is satisfied that the nursing student can safely administer drugs; and

(d) the nursing student who administers the drugs does so under the supervision of the member of the registered nursing staff. O. Reg. 218/13, s. 1 (2).

And in accordance with O.Reg 79/10 s. 131 (8), in this section, the "nursing student" means a person,

(a) who is enrolled in an educational program, the successful completion of which meets the educational requirements for the issuance of a certificate of registration as a registered nurse or registered practical nurse as set out in the regulations made under the Nursing Act, 1991, and

(b) who is working in the long-term care home as part of the clinical placement requirement of the educational program pursuant to an agreement between the licensee and the university or college that offers the educational program. ("étudiante infirmière ou étudiant infirmier") O. Reg. 79/10, s. 131 (8); O. Reg. 218/13, s. 1 (3).

During the course of the Resident Quality Inspection, Staff #S117 was observed on several day shifts providing care and services to Residents in the home in the capacity of a Personal Support Worker (PSW).

In reviewing staffing schedule for the period of July 19 to August 15, 2014, it was noted that Staff #S117 was scheduled as Registered Practical Nurse on the following day shifts:
• July 25 & 30, 2014
• August 2, 3, 8 and 13 2014

This home provides care and services to 46 residents on three floors. The registered practical nurse during the day is responsible to administer drugs to all 46 residents, as prescribed.

On August 8, 2014 at 08:20, Inspector #545 observed Staff #S117 administering oral drugs to residents on the 3rd floor. When asked if she was a registered practical nurse (RPN) or a registered nurse (RN), Staff #S117 indicated that she was not a RPN or RN. Staff #S117 indicated she was a nursing student going back to university in September 2014. Staff #S117 indicated that the DOC was aware that she did not have a license to practice as RN or RPN, and that the DOC allowed her to practice as a Registered Practical Nurse, as well as PSW.

On August 8, 2014 at 08:45, during an interview with the RAI Coordinator/Acting DOC, she indicated that she thought Staff #S117 had a temporary license to practice as RPN. In discussion with the Assistant Administrator (Office Manager), she indicated that Staff #S117 had no RPN or RN license, and was not working in this long term care home as part of a clinical placement. The Assistant Administrator added that the DOC had given her permission to schedule Staff #S117 as RPN on all three floors of the home.

On August 8, 2014 at 08:50, during a phone interview with the Administrator, she indicated to Inspector #126 that she was aware that Staff #S117 was not a RPN and that the home was scheduling this staff as RPN. The Administrator indicated that she thought it was acceptable to schedule Staff #S117 in the capacity of RPN being that she was going back to University in September 2014 to finish the nursing program. (545)

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

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.

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 8th day of August, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Angele Albert-Ritchie

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