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
Direction de l'amélioration de la performance et de la conformité

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 10, 2014	2014_321501_0006	T-139-14	Resident Quality Inspection

Licensee/Titulaire de permis

SHEPHERD VILLAGE INC.
3758/3760 Sheppard Avenue East, TORONTO, ON, M1T-3K9

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

SHEPHERD LODGE
3760 Sheppard Avenue East, TORONTO, ON, M1T-3K9

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

SUSAN SEMEREDY (501), JOELLE TAILLEFER (211), VALERIE PIMENTEL (557), VERON ASH (535)

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): May 13, 14, 15, 16, 20, 22, 23, 26, 27, 28, 29, 30 and June 2, 2014.

This inspection was conducted concurrently with a complaint inspection (T-852-13), four critical incidents (T-846-13, T-848-13, T-849-13, T-853-13) and findings from these are contained in this report. An environmental inspector also completed a complaint inspection (T-262-14) and an environmental inspector from the Ottawa service area office followed up on a past due order (T-847-13).

During the course of the inspection, the inspector(s) spoke with the vice president/client care (VP/CC), director of nursing (DON), information systems manager, payroll administrator, marketing assistant, human resources manager, manager resident quality, facility manager, facility department coordinator, food and nutrition services managers, registered dietitian (RD), physiotherapist, manager of recreation and volunteer, resident assessment instrument minimum data set (RAI-MDS) co-ordinator, nurse managers, registered nursing staff, personal support workers (PSWs), dietary aides, maintenance staff, residents and substitute decision makers.

During the course of the inspection, the inspector(s) conducted observations and reviewed resident and home records.

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents.

On May 28, 2014, inspector #557 observed on the seventh floor of the north wing, an unattended maintenance cart in the hallway. Interview with an identified maintenance staff confirmed that he/she left the maintenance cart unattended and this was not safe because there was a knife and a ladder accessible to residents and visitors. Interview with the facility manager confirmed that maintenance staff must keep their carts within eye sight at all times. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment by keeping maintenance carts inaccessible to residents and visitors, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Record review and staff interview confirmed that the nurse manager became aware of resident #701's new responsive behaviour. The nurse manager made a referral to the behaviour support team who implemented strategies to support the resident behaviour, however these strategies were not shared with all staff involved in the

different aspects of the resident's care and were not included in the plan of care or implemented consistently. [s. 6. (4) (a)]

2. The licensee failed to ensure that the care is provided to the resident as specified in the plan.

Record review revealed that on a certain date, the physician ordered responsive behavior monitoring for resident #710, to assess the resident's response to the administration of a particular medication. Responsive behaviour monitoring was initiated by the staff, however on a certain day during a certain time period, the responsive behaviour monitoring documentation was not completed by staff. [s. 6. (7)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

On a certain day, the inspector and an identified registered staff observed that resident #249 was lying in bed with one full side rail elevated. Interview with an identified PSW indicated that one side rail is elevated during the night for safety and record review revealed that this is not documented in the plan of care. Interview with the physiotherapist revealed that resident #249 was initially assessed and at that time side rails were not necessary.

Interview with registered staff confirmed that resident #249 was not reassessed and the plan of care reviewed and revised when the resident's needs changed to include the use of one full side rail at night for safety. [s. 6. (10) (b)]

4. The licensee failed to ensure that when a resident is reassessed and the plan of care is reviewed and revised, if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

Record review revealed and staff interview confirmed that resident #704 has a certain physical impairment. The resident's plan of care identified that help and support were required for other areas of activities such as transferring, feeding, toileting, and safety because of this impairment. On a certain date, due to this impairment, the resident mistakenly entered resident #705's room which lead to an altercation. On another date, resident #704 again mistakenly entered resident #705's room, resulting in a second altercation. After the first altercation, resident #704's plan of care was not

revised to include different approaches to prevent the resident from wandering into other residents' rooms.

Record review revealed that resident #710 was admitted to the home on a certain date. Since the admission, the situation had been challenging for other residents, family members, and staff. The resident's responsive behaviors were identified and documented. There were also documented complaints from residents and family members who were concerned about their loved ones safety on the unit. The responsive behaviours continued uncontrolled for a period of months until the resident was transferred to an acute care facility on a certain date. The resident's documented plan of care was notably revised every three months, but with no differences in the strategies or interventions employed until the transfer months later. [s. 6. (11) (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 staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed, that the care is provided to the resident as specified in the plan and that when a resident is reassessed and the plan of care is reviewed and revised, if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home's equipment is maintained in a safe condition and in a good state of repair.

On May 14, 2014, at 2:30 p.m., the inspector observed that the call system above resident #241's bed was completely removed from the wall and the electric wires were exposed. Interview with the registered staff indicated that he/she was informed by a PSW in the morning that the call system was removed from the wall but he/she was not aware that the wires were exposed. Interview with the registered staff confirmed that the call system equipment was in an unsafe condition and it should have been repaired immediately. On May 14, 2014, at 2:50 p.m., the inspector observed that the call system in resident #241's room was repaired and in a safe condition [s. 15. (2) (c)]

2. On May 14, 2014, the inspector observed that resident #237's call system above his/her bed was not functioning. Interview with an identified PSW revealed that he/she was not aware of the non-functioning call system. On the same day, the identified PSW contacted maintenance and the inspector observed that the call system was repaired. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's equipment is maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: 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,
(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 failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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.

Record review and staff interviews revealed that resident #294, had a fall on a certain date and sustained altered skin integrity. The registered nursing staff applied a dry dressing. The resident's plan of care did not include an assessment of the resident's altered skin integrity using a clinically appropriate assessment instrument.

Record review and staff interview revealed that resident #241 had altered skin integrity and that a scab had come off of the area. The registered nursing staff member applied tegaderm to the area. The resident's plan of care did not include an assessment of the resident's altered skin integrity using a clinically appropriate assessment instrument.

Record review and staff interviews revealed that resident #198 had altered skin integrity on different areas of his/her body. The registered nursing staff member applied an ointment to the areas and where possible applied dressings. The resident's plan of care did not include an assessment of the resident's altered skin integrity using

a clinically appropriate assessment instrument.

Interviews with registered staff confirmed that skin assessments for residents #294, #241 and #198 using the home's clinical assessments tools were not completed. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff.

Record review and staff interviews revealed that resident #294 had a fall on a certain date, and sustained altered skin integrity. The altered skin integrity was not reassessed at least weekly by a member of the registered nursing staff and in the home's skin assessment tool.

Record review and staff interviews revealed that resident #241 had altered skin integrity and that a scab had come off. The registered nursing staff member applied a dressing to the area. The altered skin integrity was not reassessed at least weekly by a member of the registered nursing staff and in the home's skin assessment tool.

Record review and staff interviews revealed that resident #198 had a pressure ulcer and multiple areas of altered skin integrity. The resident's plan of care identified that the homes skin assessment tools were to be completed by a member of the registered nursing staff on a weekly basis. The skin assessment tool was not completed on four particular dates.[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 every resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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 and is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviors, strategies are developed and implemented to respond to these behaviors.

Record review revealed that the staff and DON were aware of resident #704's demonstrated responsive behaviours. On two particular dates, resident #704 demonstrated particular responsive behaviours which caused injuries to resident #704 on both occasions. Resident #704's plan of care did not identify the particular responsive behaviour and strategies and interventions were not developed and implemented to respond to the behaviour.

Record review revealed that resident #707 had responsive behaviours. On two particular dates, after an altercation with another resident, the police were called and during questioning of the resident, the police conducted a search. They found some identified dangerous items. In addition, another staff removed dangerous items from the resident's room that same evening. An identified PSW also reported seeing the resident with dangerous items; however they were not located during the search. Although the resident's plan of care identified the responsive behaviour, there were no specific interventions or strategies listed to guide staff related to his identified responsive behaviour. [s. 53. (4) (b)]

2. The licensee failed to ensure that, for each resident demonstrating responsive behaviors, actions are taken to respond to the needs of the residents, including assessments, reassessments, and interventions and that the resident's responses to interventions are documented.

Record review revealed that resident #707 was in an altercation with another resident on a certain date, and the behavior monitoring documentation was initiated. However, on a certain dates within certain times the behavior monitoring documentations were not completed by staff. [s. 53. (4) (c)]

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, for each resident demonstrating responsive behaviors, strategies and actions are developed and implemented to respond to these behaviours and responses to interventions are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

Record review revealed that resident #707 had identified responsive behaviours. The resident had numerous word exchanges and altercations documented. On a certain date, the resident had an argument with another resident and threatened the other resident. In another incident, resident #707 displayed inappropriate behaviour to another resident and the other resident threw an identified item. These examples demonstrated potentially harmful interactions between residents and the situation remained unchanged. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff concerning the care of a resident or operation of the home is dealt with.

Record review revealed that resident #701's Power of Attorney (POA) sent a written complaint to the home on a certain date. An interview with the DON confirmed that management was aware of the family complaint, but that they did not investigate and resolve the issue, nor responded to the family in writing within 10 business days. [s. 101. (1) 1.]

2. The licensee failed to ensure that a documented record was kept in the home that includes the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response and any response made by the complainant.

Interview with a family member of resident #327 revealed that he/she had made complaints to the home regarding a few issues. The family member stated he/she made these complaints to PSWs, the facility department coordinator, registered staff, a nurse manager and the DON. Interview with the nurse manager and DON revealed that they could not remember specifically any of these issues but admitted they could have occurred since not every issue or concern is considered a complaint and documented.

Interview with a family member of resident #249 revealed that he/she had voiced several times over the course of at least a year to the DON that he/she thought the dining room was crowded and unsafe. Interview with the DON confirmed that this family member had spoken to him/her regarding this issue for at least a year and this issue had yet to be resolved. The DON confirmed that there is no documentation of this complaint. [s. 101. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every written or verbal complaint made to the licensee or a staff concerning the care of a resident or operation of the home is dealt with and a documented record is kept in the home that includes the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response and any response made by the complainant, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 215. Criminal reference check

Specifically failed to comply with the following:

s. 215. (2) The criminal reference check must be,
(a) conducted by a police force; and O. Reg. 79/10, s. 215 (2).
(b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee. O. Reg. 79/10, s. 215 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a criminal reference check is conducted by a police force and within six months before the staff member is hired by the licensee.

Record review revealed that an identified employee commenced employment on a certain date, and did not submit a criminal reference check. In the employee's offer letter, the criminal reference check was noted to be a condition of employment. In a subsequent letter to the employee, a deadline was given to submit the criminal reference check before a certain date. Another letter was sent to the employee which indicated that the criminal reference check still had not been submitted to the home.

Staff interviews confirmed that this employee continues to work at the home without having submitted his/her criminal reference check. [s. 215. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a criminal reference check is conducted by a police force and within six months before the staff member is hired by the licensee, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining
Specifically failed to comply with the following:

s. 219. (1) The intervals for the purposes of subsection 76 (4) of the Act are annual intervals. O. Reg. 79/10, s. 219 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff receive annual training in Residents' Bill of Rights and the home's policy to promote zero tolerance of abuse and neglect of residents and mandatory reporting.

Record review and interview with marketing assistant indicated that only 50 per cent of staff received annual training in Residents' Bill of Rights and only 43 per cent in the home's policy to promote zero tolerance of abuse and neglect and mandatory reporting in 2013. The home's 2013 education calendar ranges from April 1, 2013 to March 31, 2014. [s. 219. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff receive annual training in Residents' Bill of Rights and the home's policy to promote zero tolerance of abuse and neglect of residents and mandatory reporting, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provides direct care to residents received, as a condition of continuing to have contact with the residents, annual training in abuse recognition and prevention.

Record review and interview with the marketing assistant indicated that only 47 per cent of staff who provided direct care to residents received training in abuse recognition and prevention in 2013. The home's 2013 education calendar ranges from April 1, 2013 to March 31, 2014. [s. 221. (2) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff who provides direct care to residents received, as a condition of continuing to have contact with the residents, training in abuse recognition and prevention, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that staff are screened for tuberculosis in accordance with evidence-based practices.

Record review revealed that an identified employee started employment on an identified date, and another identified employee started employment on another identified date. Both of these employees have not submitted results of their two-step mantoux skin test, in accordance to the home's evidence based practice.

Staff interviews confirmed that both employees are employed and working without having submitted their screening results for tuberculosis. [s. 229. (10) 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 each resident admitted to the home be screened for tuberculosis within 14 days of admission and staff are screened for tuberculosis in accordance with evidence-based practices, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that a written record is created and maintained for each resident of the home.

On Friday, May 23, 2014, the inspector requested documentation related to behavior monitoring documentation for eight residents in the home to support the inspection of four critical incidents reported by the home. The home was unable to produce the documents on the requested date; however, on Monday, May 26, 2014, the inspector was given a folder with a copy of the requested documents, with the exception of one.

Record review and staff interviews confirmed that resident #s 360, 702, 703, 704, and 708's behaviour observation documentation were all recopied by an identified PSW during the week-end of May 24 and 25, 2014, because the original documents were in a less than desirable state – wrinkled with water-mark stains on most of them. The original copies of the resident's documents were disposed of in a recycling bin. Staff interview confirmed that the recycling bins are gathered into a larger disposal container in the back of the building and picked up by the city's disposal unit.

The inspector also observed that residents' archived documents were kept in poor condition and not stored in a manner that would maintain their integrity. [s. 231. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a written record is created and maintained for each resident of the home, to be implemented voluntarily.

WN #13: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
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).

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).

19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that residents' personal health information within the meaning of Personal Health Information Protection Act, 2004, is kept confidential in accordance with the Act.

Record review and staff interviews confirmed that resident #s 360, 702, 703, 704, and 708's behaviour observation documentation were all recopied by an identified PSW during the week-end of May 24, 25, 2014, because the original documents were in a less than desirable state – wrinkled with water-mark stains on most of them. The original copies of the resident's documents were disposed of in a recycling bin. Staff interview confirmed that the recycling bins are gathered into a larger disposal container in the back of the building and picked up by the city's disposal unit. [s. 3. (1)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure where the Act or this regulation requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with.

On two particular days, resident #705 was involved in two altercations with another resident on their home unit. In both instances, behavior monitoring documentation was not initiated for resident #705 by the staff, although the resident was involved in an altercation and sustained minor injuries. A resident abuse/assault incident report was not completed for resident #705 by staff related to the incident on one of the days, and the incident was not reported to the Director using the critical incident reporting system.

The altercation on the other day, resulted in resident #705 being pushed and hit. Although an injury routine monitoring was initiated by staff, during one of the required checks, staff did not awaken the resident for the injury assessment and completion of vital signs, and instead the word 'sleeping' was written next to the time slot. In addition, staff did not complete a falls incident documentation using a clinically appropriate instrument for the fall.

Record review of the home's resident to resident abuse/assault policy #NURS VI - 117, dated February 2011, indicated that accurate and complete documentation of all incidents, continuous assessment of potential for incidents, complete resident abuse/assault incident report, notification of the Ministry of Health and Long Term Care, and initiation of behaviour monitoring documentation were all required steps to be completed by the staff. An interview with the DON confirmed that the completion of all documents as listed in the home's policy, and including the falls incident assessment using a clinically appropriate instrument should have been completed after the altercation resulting in a fall. [s. 8. (1) (a),s. 8. (1) (b)]

2. The home's policy titled Self-Administration of Medication revised February 2014, indicated that medication will be securely stored in a locked drawer or locked box.

Record review revealed that resident #501 had an order for self-medication administration. On a certain date, the inspector observed that resident #501 had his/her prescribed medication in an unlocked drawer in his/her room.

Interview with the registered staff confirmed that the home is not following their self-administration medication policy. [s. 8. (1) (b)]

3. The home's policy titled Emergency Stock Box dated February 2014 indicates that the night Float RN will conduct a monthly audit of the emergency stock box to facilitate re-ordering of medications expired or missing from the medication list.

On May 23, 2014, the inspector observed nine Clindamycin capsules were expired since March 2014, in the emergency stock box on the fourth floor. Interview with an identified registered staff and the DON confirmed that these medications found in the emergency stock box were expired. [s. 8. (1) (b)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is available at each bed, toilet, bath and shower location used by residents.

On a certain date, inspector #501 observed that there was no call system at resident #249's bedside. Interview with the DON indicated that the family requested to remove the call system at the resident's bedside. Interview with the DOC revealed that the home suggested one alternative but the family declined. Interview with the registered staff and the DON confirmed that a call bell system should be available at the bedside at all times and the home had not explored all alternative strategies. On a certain date, inspector #211 observed that the call bell system was available at the resident's bedside with a shortened cord. [s. 17. (1) (d)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a written complaint concerning the care of a resident or the operation of the long term care home shall immediately be forwarded to the Director.

Record review revealed that resident #701's POA sent a written complaint to the home on a certain date. An interview with the DON confirmed that management was aware of the family complaint, but that they did not investigate, resolve the issue, nor responded to the family in writing within 10 business days. In addition, the home did not forward the complaint to the Director. [s. 22. (1)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported to the licensee, is immediately investigated.

On a certain date, resident #353 stated, in the presence of the inspector and two members of the registered nursing staff, that evening staff shoved him/her and broke a bone.

Record review of the progress notes for a particular date, revealed a documented incident involving resident #353, a registered nursing staff, and a PSW. The resident during the care that was being rendered identified that the registered nursing staff and the PSW broke some bones. This documentation supported the resident's statement.

Record review revealed that there was no assessment of the resident to see if bones were broken, bruised, discolored or swollen on a certain date, by the registered nursing staff. The 24 hour summaries from two particular dates were reviewed and the reports did not identify the incident between the resident, registered nursing staff and the PSW. The registered nursing staff member did not report this incident or communicate this to the night nurse manager or float day charge nurse in order to investigate the alleged abuse to resident #353.

The day charge nurse and nurse manager confirmed there was no investigation into the abuse of the resident. [s. 23. (1) (a)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure there is a system to monitor and evaluate the food intake of residents with identified risks related to nutrition.

Review of the home's policy #NURS IX-166 titled Food Intake – Residents in Dining Room, revised March 2014, indicates that PSWs will monitor and record the food and fluid intake of those residents identified at nutritional risk and report any relevant information to the unit nurse.

Interview with PSWs revealed that there is no consistent reporting of poor food intake. Some PSWs will report poor intake to the unit nurse when a resident is eating less than 100 per cent while others will report when intake is less than 75, 50, or 25 per cent. Some PSWs will report poor intake right away while others will report after intake is poor for a few days. Interview with registered staff revealed that they do not monitor intake on a regular basis and rely on PSWs to inform them when intake has changed.

Interview with the RD revealed that his/her expectation is that residents consuming less than 50 per cent over a period of two or three days would be reported to the unit nurse and a referral made to the RD. The RD confirmed that his/her expectations have not been formalized into a system to monitor and evaluate his/her expectations.

Interview with the RD further revealed that food intake is difficult to monitor and evaluate because the computer system does not facilitate an overview of intake for a certain period of time. In order to evaluate intake, the process involves looking at daily intakes on the computer and manually charting a report in order to evaluate whether a resident is meeting his/her estimated daily nutritional needs. [s. 68. (2) (d)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that actions were taken using an interdisciplinary approach when residents have had weight change that compromises their health status.

Record review revealed that resident #225 had a slow progressive weight loss for a certain time period, and was described in the plan of care as being underweight and a low body mass index. A food and nutrition service supervisor completed a quarterly nutritional assessment on a certain date and a new goal to gain weight in the next quarter was established. Review of the diet list and interview with an identified PSW revealed that no action or new intervention that would make this goal possible had been implemented. Interview with the RD confirmed that a new intervention such as, high calorie snacks should have been implemented. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that planned menu items are offered at each meal.

On May 13, 2014, the inspector observed that residents on minced textured diets did not receive the planned menu item. Record review revealed that one of the menu options for the lunch entrée was grilled cheese sandwich and the therapeutic spreadsheet indicated those on a minced textured diet should receive a cheese sandwich. The inspector observed and staff interviews confirmed that these residents were served a minced meat (chicken or tuna) sandwich and not the cheese sandwich as on the planned menu.

On May 13, 2014, the inspector observed that residents on a reducing and diabetic diet were not offered diet vanilla pudding as planned. Record review revealed the options for dessert at lunch included tapioca pudding or pears. The therapeutic spreadsheet indicated those on a reducing or diabetic diet should be offered diet vanilla pudding or pears. The inspector observed and staff interviews confirmed that these residents were only offered the pears or grapes and not offered diet vanilla pudding. [s. 71. (4)]

WN #21: 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).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act.

The licensee failed to ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act.

Record review revealed that 80 per cent of staff did not receive retraining in infection prevention and control in 2013.

Interview with the marketing assistant and the nurse manager confirmed that not all of the staff received retraining in infection prevention and control in 2013. [s. 76. (4)]

2. The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in behavior management.

Record review revealed and an interview with the DON confirmed that 75 per cent of staff who provide direct care to residents did not complete the training related to the behavior management program in 2013. [s. 76. (7) 3.]

WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to ensure that inspection reports from the past two years are posted in the home, in a conspicuous and easily accessible location.

On May 13, 2014, the inspector observed that only four of the 11 public inspection reports were posted in a locked cabinet on the main floor and only the front page of the reports were readable.

The following public inspection reports were not posted -
2014_274535_0005
2014_317703_0002
2013_220111_0018
2013_220111_0004
2013_178102_0012
2013_220111_0003
2012_031194_0037

Staff interviews confirmed that not all inspection reports within the last two years were posted. [s. 79. (3) (k)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or medication cart that is secure and locked.

On May 28, 2014, the inspector observed that the door to the seventh floor nursing station was unlocked and accessible to visitors and residents. The inspector observed an unlocked treatment cart inside the nursing station with prescription topical medications. Interview with registered staff confirmed that the door and the treatment cart should have been locked. [s. 129. (1) (a) (ii)]

Issued on this 14th day of July, 2014

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

J. Kennedy