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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 24, 2015	2015_413500_0004	T-1732-15	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

SHERWOOD COURT LONG TERM CARE CENTRE
300 Ravineview Drive Maple ON L6A 3P8

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

NITAL SHETH (500), JOELLE TAILLEFER (211), SARAN DANIEL-DODD (116)

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): March 18, 19, 20, 23, 24, 26, 27, 30, 31, April 1, 2, 2015.

The following complaint inspection intakes were inspected during this RQI: T-929-14, and T-1021-14.
The following critical incident intakes were inspected during this RQI: T-2154-15, T-2094-15, T-2060-15, and T-2059-15.
The following followed up order intake was inspected during this RQI: T-1850-15.

During the course of the inspection, the inspector(s) spoke with the executive director (ED), director of care interim (DOC), associate director of care interim (ADOC), , RAI Coordinator, environmental service supervisor, registered dietitian (RD), food service supervisor (FSS), physiotherapist, physiotherapy assistant, nursing administrator from the Staff Relief Healthcare Services, registered nursing staff, activity aide, dietary aide, personal support workers (PSWs), residents, and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

18 WN(s)
12 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 221. (2)	CO #001	2014_251512_0006	500

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
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).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to be properly cared for in a manner consistent with his or her needs.

Review of the resident #15's written plan of care indicated that the continent brief needs to be changed in bed with the assistance of two staff before meals, in the evening at an identified time period, and at bedtime and as needed.

Interview with the Power of Attorney (POA) revealed that on an identified day, the resident requested to have the brief changed as he/she had a bowel movement. When the resident asked the staff to be changed, he/she was told that they were not going to put him/her to bed to change the brief and then have to get him/her up again for meal time. The family member indicated that the resident was found several times with a urine soaked wheelchair pad.

Interview with an identified PSW revealed that on an identified day, the resident was found with a dirty brief and soiled with bowel movement during shift change time. The identified staff was informed by the resident that he/she asked to have his/her brief change during the day shift. The resident was told that if he/she was put back in his/her bed to have his/her brief change before lunch, he/she will need to stay in bed for lunch because they were not putting him/her back in the wheelchair. The resident decided to stay in the wheelchair with a dirty brief because he/she did not want to stay in bed. The identified PSW stated that the resident's right was not respected.

Record review of the critical incident report about the another incident happened on an identified day indicated that the resident and the family member claimed that the resident was left soaked and drenched of urine up to her wheelchair cushion. On that day, the resident was not toileted before dinner time because an identified registered staff member told the resident that he/she cannot go to bed at that time and to go for the dinner in the dining room.

Interview with the interim ADOC confirmed that the resident's brief was not changed prior the dinner time as requested by the resident and that he/she was not properly cared for in a manner consistent with his or her needs. [s. 3. (1) 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 every resident has the right to be properly cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #2: 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 has failed to ensure that the home is a safe and secure environment for its residents.

On March 23, 2015, the inspector observed that the kitchen door in the Maple Lane wing on the second floor did not lock properly since rattling the handle would unlock it. The kitchen may constitute a hazardous area as it contains a stove, a warmer and hot water machine.

Interview with the interim ADOC, confirmed that the kitchen door lock was not functioning properly and maintenance staff will be informed.

On March 24, 2015, the inspector observed that the kitchen door lock was repaired. On March 27, 2014, interview with the maintenance manager confirmed that the kitchen door was loose and repaired on March 23, 2015. [s. 5.]

2. On March 31, 2015, at approximately 11:30 a.m., the shower/tub room located on Noble's Corner was observed to be open, unlocked and unattended. The floor was observed to be wet and posed a slip hazard for residents. Residents were observed within the surrounding area.

Interview with a PSW and the interim ADOC confirmed that the shower/tub room door is to be closed and locked when unattended. [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 for its residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan.

On an identified day, resident #38, who is cognitively impaired was discovered in resident #37's room. Resident #38 was observed removing the blanket from resident #37. There were no injuries as a result of the incident. The written plan of care was updated on an identified day, for resident #37 to instruct staff to apply a specified intervention to the resident's door to deter anyone from entering in his/her room to prevent anxiety and fear.

On March 30, 2015, at approximately 4:00 p.m., the inspector observed the specified intervention was not in place to resident #37's door. The assigned PSW confirmed being unaware as to whether the specified intervention is to be in place at all times and was unable to locate a specified intervention.

Interview with the resident's Power of Attorney (POA) revealed that there have been several occasions where the specified intervention was not in place.

Interviews held with the registered staff, PSW's and the interim ADOC confirmed that the specified intervention should be in place at all times. [s. 6. (7)]

2. Resident #38 exhibits responsive behaviours due to cognitive impairment. The written plan of care for resident #38 directs staff to monitor the resident whereabouts every 30

minutes to keep the resident and other residents safe.

Interviews held with PSWs assigned to the resident stated that they monitor the resident's whereabouts on an hourly basis.

Interviews held with the interim ADOC confirmed that resident #38 is to be monitored every 30 minutes and that the care regarding the resident's monitoring was not provided as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Review of resident #4's treatment administration record (TAR) for an identified month, indicated to change the identified dressing-A every day on an identified wound. Review of the TAR for an identified month, indicated that the ordered dressing-A was not available on four identified days.

Interview with an identified registered staff indicated that the identified dressing-A was not available on the identified days and he/she cleaned the wound with normal saline and applied another dressing-B.

Interview with the interim ADOC indicated that the home received two boxes of identified dressing-A on an identified day, and it was not communicated to him/her by the registered staff that the identified dressing-A was not available on four identified days. The interim ADOC confirmed that both dressing products (A and B) do not have the same purpose for wound treatments and the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

4. The licensee has failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care.

A review of resident #29' plan of care revealed that the resident returned from the hospital on an identified day. His/her status was changed to palliative and he/she was NPO since then.

Interview with dietary aide, who was serving food in the dining room confirmed that he/she was not aware that the resident was NPO (nothing by mouth); his/her diet sheet was not changed.

Interview with the charge nurse, who was monitoring in the dining room confirmed that he/she was not aware about the resident being NPO.

Interview with the FSS confirmed that staff members should be aware about NPO status of the above mentioned resident. [s. 6. (8)]

5. The licensee has failed to ensure that the provision of the care set out in the plan of care is documented.

Review of the resident #4's treatment administration record (TAR) and interview with an identified nursing staff indicated that the specified dressing was changed daily on the identified wound but was not documented on specified days.

Review of the resident #4's TAR and interview with the interim ADOC revealed that the specified dressing on the identified wound was not documented on specified dates, and the resident's care was assigned to the staff relief Agency. Interview with the nursing administrator from the Staff Relief Healthcare Services indicated that the registered staff from the agency was called to ask if the identified dressing was performed. The registered staff from the agency did not remember if the identified dressing was administered to the wound.

Review of the resident #4's TAR and interview with the identified registered staff employed at the home revealed that the identified dressing on the identified wound was administered but was not documented on three days in an identified month.

Interview with the interim ADOC confirmed that the identified dressing was not documented on the resident's plan of care on three days in three identified months. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that,
- the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care, and
- the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care
- that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect neglect of a resident by the licensee or staff has occurred or may occur immediately report the suspicion and the information upon which it is based to the Director.

Review of the resident #15's written plan of care indicated that the continent brief needed to be changed in bed with the assistance of two staff before meals, on identified time in the evening, at bedtime and as needed.

Record review of the critical incident report submitted on August 29, 2014, and interview with the interim ADOC indicated that the resident #15 and the family complained on an identified day, that an identified registered staff told the resident that he/she cannot be toileted before going to the dining room.

Interview with an identified registered staff confirmed that the resident was not toileted before supper. Record review indicated that the resident was put in bed and toileted at 7:00 p.m.

Interview with the ED confirmed that the licensee did not immediately report to the Director the suspicion of the alleged neglect of a resident by the staff. [s. 24. (1) 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 person who has reasonable grounds to suspect neglect of a resident by the licensee or staff has occurred or may occur immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care is based on, at a minimum, interdisciplinary assessment of the communication abilities, including hearing and language with respect to the resident.

A review of resident #3's MDS assessments completed on three identified quarters indicated that the resident's speech changed from clear speech to unclear speech. This was a significant change in the resident's communication abilities.

A review of the resident's plan of care revealed that the plan of care had no information about residents' communication, hearing and language abilities. This information was included in the plan of care on an identified day, after the inspector notified to the home.

Interview with the registered nursing staff confirmed that the resident has unclear speech and has some language barrier. The registered nursing staff also indicated that the resident's plan of care did not include above mentioned information related to communication prior to the identified day.

Interview with the interim ADOC confirmed that the resident's communication including resident's hearing and language abilities should be included in the written plan of care. [s. 26. (3) 3.]

2. The licensee has failed to ensure that an interdisciplinary assessment with respect to the resident's special treatments and interventions.

Resident #15 is identified at high risk for skin impairment. On an identified day, the resident was observed with an alteration in skin integrity. Four days later, a referral was made to the physician and to the RD for follow up on altered skin integrity.

The written plan of care does not reflect skin impairment issues and treatments and interventions in place to manage the stage two pressure ulcer.

Record review revealed and interview with the interim ADOC confirmed that the plan of care for resident #15 regarding pressure ulcers does not include special treatments and interventions. [s. 26. (3) 18.]

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 an interdisciplinary assessment with respect to the resident's special treatments and interventions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Interview with the resident #15's Power of Attorney (POA) revealed that the resident's specified body areas were hit by the mechanical lift during a transfer.

Review of the progress notes indicated that resident specified body area bumped into the front of the lift during the transfer.

Review of the progress note made on a identified day indicated that the resident reported his/her concerns to management that he/she sustained bruises as a result of a transfer which was confirmed by the staff in his/her assessment.

Interview with an identified PSW revealed that the resident's specified body area hit the tip of the handle of the Hoyer lift but there was no visible redness.

Interview with an identified registered staff indicated that the resident's specified body area touched the front of the Hoyer lift while being transferred from the wheelchair to the bed on an identified day. He/she revealed that the resident's specified body area should not touch the front of the mechanical lift when the sling is properly positioned. The identified registered staff confirmed that the sling was not properly positioned under the resident body before the transfer and the resident's specified body area was too close to the front part of the Hoyer lift during his/her transfer.

Interview with the interim ADOC confirmed that the sling of the Hoyer lift must not have been positioned appropriately if the resident's specified body area hit the front of the mechanical lift on an identified day. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #7: 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 has failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach and those actions are taken and outcomes are evaluated:
- A change of 5 per cent of body weight, or more, over one month.
- A change of 7.5 per cent of body weight, or more, over three months.
- A change of 10 per cent of body weight, or more, over 6 months.
- Any other weight change that compromises the resident's health status.

A review of resident #15's plan of care revealed that the resident had a significant weight change 5%, 7.5%, and 10% in an identified month. A review of a plan of care does not indicate an interdisciplinary assessment made for above mentioned significant weight change.

A review of the home's policy # LTC-G-60, titled "Height Measurement and Weight Management", revised June 2014, indicates that if a weight loss or gain is 2.0 Kg or greater from the preceding month, the weight will be confirmed immediately. The RD is responsible to review the monthly weight report at the end of each month to ensure all significant weight change has been addressed.

Interview with the RD confirmed that he/she did not receive a referral for the resident's significant weight change in an identified month. Weight gain is not usually his/her priority and the resident was being overweight most of the time. Therefore he/she missed out looking for significant weight gain for the resident in his/her monthly report and assessment was not completed. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with the following weight changes are assessed using an interdisciplinary approach and those actions are taken and outcomes are evaluated:
- A change of 5 per cent of body weight, or more, over one month. - A change of 7.5 per cent of body weight, or more, over three months.
- A change of 10 per cent of body weight, or more, over 6 months. - Any other weight change that compromises the resident's health status, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): An injury in respect of which a person is taken to hospital.

A review of resident #1's plan of care revealed that the resident had a fall and was sent to the hospital on an identified day. The home received a call on a same day from the hospital indicating that the resident sustained an injury and required a surgery.

A review of Critical Incident (CI) Report #2894-000028-14 revealed that the CI was not submitted in one day to Ministry of Health (MOH). [s. 107. (3) 4.]

2. Review of the progress notes record indicated that resident #10 had a fall on an identified day and sustained an injury. The progress notes indicated that the licensee was informed about resident's injury on a same day, and he/she received surgery on a next day.

Review of the critical incident report indicated that the licensee did not informed the Director in one day.

An interview with the ED confirmed that the above mentioned incidents were not submitted to MOH within one business day. [s. 107. (3) 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 the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): An injury in respect of which a person is taken to hospital, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

On an identified day, 12 pre-poured pills were observed to be stored in a white medication cup in the 2nd unit medication cart. Interview held with the assigned registered staff member indicated that the medications were the scheduled 8:00 a.m., pills for resident #40. The medication administration record was not documented to record the resident's refusal of the medications.

Interview with the registered staff and further interview with the interim ADOC and ED confirmed that pills are to be disposed of at the time of refusal and not kept for re-administration. [s. 126.]

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 drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #10: 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 ensure that drugs are stored in an area or a medication cart that is secure and locked.

On March 24, 2015, at approximately 12:15 p.m., the medication cart on Noble's corner (1st floor) was stored in the hallway outside of the dining room and observed to be unlocked and unattended. The registered staff member assigned to the medication cart confirmed that the medication cart should be locked at all times when unattended.

Further interviews held with the interim ADOC and the ED confirmed that the medication carts are to be locked at all times when unattended. [s. 129. (1) (a)]

2. The licensee has failed to ensure that 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.

On March 26, 2015 at approximately 4:00 p.m., the inspector observed the narcotic bin located in the medication cart on Via Roma was not double locked. The registered staff member assigned to the cart was able to gain access to the bin without the use of the key.

Interviews held with the registered staff member and the interim DOC confirmed that the stationary cupboard for controlled substances is to be double locked at all times when not in use. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that
- drugs are stored in an area or a medication cart that is secure and locked
- 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, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Resident #37 was admitted to the home on an identified day. Upon admission the written plan of care documented that the resident has an allergy to a specified medication.

On a specified date, the physician gave a telephone order prescribing an identified medication to treat an alteration in skin integrity. The registered staff member transcribed the order and documented that the resident had no known allergies. Resident #37 commenced the therapy on an identified day and received six schedules doses. Upon discovery of the medication error the medication was discontinued. The resident did not experience any signs of an allergic reaction to the identified medication.

Record review revealed and interviews held with the registered staff, interim ADOC and E.D. confirmed that the medication error was reported to the resident's SDM, the interim ADOC, the resident's attending physician and the pharmacy service provider however, there is no documentation to support if any immediate actions were taken to assess and maintain the resident's health. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, to be implemented voluntarily.

WN #12: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

Observation conducted on March 18, 2015, at 12:00 p.m., in the first floor dining room, revealed that on two occasions an identified PSW removed soiled plates from residents and left them in the soiled utility cart. Without performing hand hygiene he/she served food to other residents.

Interview with the identified PSW and the charge nurse confirmed that he/she should perform hand hygiene after clearing dishes from the residents and before serving food to other residents.

Interview with the FSS confirmed that staff should perform hand hygiene after clearing dishes and before serving meals to the residents. [s. 229. (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 participate in the implementation of the program, to be implemented voluntarily.

WN #13: 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 ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

A review of the home's policy #LTC-G-60, titled "Height Measurement and Weight Management", revised June 2014, indicates, each resident's height will be measured on admission and at a minimum annually thereafter.

Review of plan of care revealed that resident #11, and #15's heights were not measured and recorded in 2011, and resident #3's height was not measured and recorded in 2014.

Interview with the RD and interim ADOC confirmed that the home have a policy to measure each resident's height on admission and annually thereafter. RD indicated that it is a requirement but the height is not always updated annually. [s. 8. (1) (b)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

Observation conducted on March 18, 2015, at 12:00 p.m., in the first floor dining room, revealed that resident #26 was served soup and resident #27 was served a main course without feeding assistance available.

A review of a plan of care of the above mentioned residents indicate that residents requires total feeding assistance.

Interview with the PSW confirmed that both the residents requires total assistance for eating.

Interview with the FSS confirmed that food should not be served to residents until feeding assistance is available. [s. 73. (2) (b)]

WN #15: 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 has failed to ensure that copies of the inspection reports from the past two years for the long-term care home are posted in the home.

On March 18, 2015, the inspector observed the following two inspection reports which were not posted on the notice board in front of the lobby.
- 2014_315702_0002 dated on March 4, 2014, and
- 2013_159178_0024 dated on December 4, 2013.

Interview with the ED confirmed that the above mentioned inspection reports were not posted as required.

On March 19, 2015, the inspector observed the above mentioned inspection reports posted in the home. [s. 79. (3) (k)]

WN #16: 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. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

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

Record review indicated that the resident #15 and the POA verbally reported to the home about the following issue:
- on an identified day, the resident complained that he/she was not toileted before dinner time because an identified registered staff told him/her that he/she cannot go to bed at that time and have his/her dinner in the dining room.
- On an identified day, the resident and the family verbally reported that there was a concern that the resident sustained bruising as a result of a transfer.
- On an identified day, the resident complained that one of the staff was very rude to him/her the other day.

Interview with the interim ADOC and the ED confirmed that the complaints were investigated according to the date received on identified days, but they cannot find the investigation documentation records in the home.

ED confirmed that the home failed to keep the documentation records of the investigations in the home. [s. 101. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Review of the professional advisory committee minutes revealed and interviews with the interim ADOC and ED confirmed that the ED did not attend the meetings held in June and September 2014. The Medical Director did not participate in the March 2014 meeting. [s. 115. (1)]

WN #18: 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 ensure that a monthly audit is 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.

Record review of the monthly narcotic count audit tool and interview with the interim ADOC confirmed that the monthly narcotic count was not conducted for the following months on the following units:
Noble's Corner- January, February, March, May, June 2014, and January 2015.
Via Roma-January, February, March, May, June, July, October 2014, and January 2015.
Maple Lane- January, February, March, April, May, June 2014, and January 2015.

Interview held with the interim ADOC confirmed that it is the home's expectation to conduct and complete a monthly audit for all controlled substances. [s. 130. 3.]

Issued on this 27th day of May, 2015

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

Original report signed by the inspector.