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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 22, 2017	2017_597655_0011	009900-17, 010078-17, 011312-17	Complaint

Licensee/Titulaire de permis

The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott
c/o St. Lawrence Lodge 1803 County Road 2 BROCKVILLE ON K6V 5T1

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

ST. LAWRENCE LODGE
1803 County Road, #2 East Postal Bag #1130 BROCKVILLE ON K6V 5T1

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

MICHELLE JONES (655)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 24, 25, 26, 30, 2017, and June 1, 2, 5, 6, 7, and 8, 2017.

During the inspection, the following Logs were inspected concurrently: Log #009900-17 (Complaint), Log #010078-17 (Critical Incident), and Log #011312-17 (Complaint).
The logs were related to allegations of staff-resident abuse and neglect; and related to the care provided to a resident related to continence care and bowel management and assistance with dressing; and, menu planning.

Note: An inspection of Complaint Log #007543-17, related to food quality and menu planning, social and recreation activities, and medications was also inspected concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with residents and family, Personal Support Workers (PSWs), registered nursing staff (RNs and RPNs), an Assistant Director of Care (ADOC), the Director of Care (DOC), Environmental Services staff, and the Nutrition Manager.

During the inspection, the Inspector also observed the provision of resident care and services, and reviewed resident health care records, policies, and menus.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 :

The licensee has failed to ensure that where the Act or 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 plan, policy, protocol, procedure, strategy or system, is complied with.

i. The licensee has failed to ensure that the policy titled "Safe Medication Administration", dated January, 2016, was complied with.

As per Ontario Regulation 79/10, s. 114 (2), the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

During the inspection, Inspector #655 conducted a medication administration observation on resident #002's resident home area at 0835 hours, for the morning medication pass.

On arriving to resident #002's resident home area for the morning medication pass, it was noted by Inspector #655 that RPN #109 had already poured all of resident #002's medications from the blister pack into a medication cup. RPN #109 was then observed to administer resident #002's medications to the resident. At no time after resident #002 had taken the medications did Inspector #655 observe RPN #109 document that resident #002's medications had been administered on the Medication Administration Record (MAR).

During an interview shortly after, RPN #109 indicated to Inspector #655 that the administration of resident #002's medication had been documented on resident #002's

MAR before they were actually given to the resident – before Inspector #655 had arrived for the observation of the morning medication pass. RPN #109 indicated to Inspector #655 that it was his/her practice to sign for the administration of all medications in advance, in order to stay organized. RPN #109 then demonstrated that the documentation was complete by showing Inspector #655 the Medication Administration Record (MAR) for resident #002.

Inspector #655 reviewed two MARs belonging to resident #002; and noted several gaps in the documentation over a two month period. There were five separate incidents in which there were no initials or other documentation to indicate whether or not a specified medication had been administered to resident #002.

During an interview, RPN #109 indicated to Inspector #655 that he/she was not aware of any medication errors involving resident #002. At the same time, Inspector #655 reviewed the MARs belonging to resident #002 with RPN #109. According to RPN #109, the missing documentation on resident #002's MARs was due to a lack of documentation, and not due to the omission of a medication. RPN #109 recalled working on one of the specified dates on which there was no documentation to indicate that a specified medication had been administered to resident #002. RPN #109 further recalled that the specified medication had been administered; and indicated that that he/she then forgot to document it.

Inspector #655 also reviewed the MARs for resident #006 and resident #007.

The MAR for resident #006 covered a period of one month. On resident #006s' MAR, there were seven separate incidents in which there were no initials or other documentation on the MAR to indicate whether or not a specified medication had been administered to resident #006.

The MAR for resident #007 also covered a period of one month. On review of resident #007's MAR, there were six instances in which there were no initials or other documentation to indicate whether or not a specified medication had been administered to resident #007.

During an interview, RPN #107 indicated to Inspector #655 that he/she was not aware of any medication errors involving either resident #006 or resident #007. During the same interview, Inspector #655 reviewed the above-listed MARs and gaps in documentation, as noted above, with RPN #107. RPN #107 indicated to Inspector #655 that the gaps in

the documentation on both of the MARs was reflective of a lack of documentation, and not due to a medication omission.

Inspector #655 reviewed the policy document titled "Safe Medication Administration", dated January, 2016.

As per the policy, registered nursing staff are responsible for preparing and administering medications, and subsequently documenting the administration on the medication administration record (MAR). The procedure for safe medication administration is outlined in the policy, with steps numbered one to ten; where the nurse is expected to ensure that the resident has ingested the medication prior to documenting on the MAR. According to the policy, "Safe Medication Administration", registered nursing staff are to initial the MAR in the appropriate location after the resident has ingested the medication. If the dose is not administered, the registered nurse is expected to make a notation in the appropriate space on the MAR.

During an interview on June 5, 2017, the DOC confirmed the expectations related to documentation on the MAR and the procedure of medication administration as per the "Safe Medication Administration" policy, dated January, 2016. At the same time, the DOC indicated to Inspector #655 that pre-pouring or pre-signing of medications is not an acceptable practice.

The licensee has failed to ensure that the policy titled "Safe Medication Administration", dated January, 2016, was complied with.

(Log # 009900-17; Log # 010078-17)

ii. The licensee has failed to ensure that the policies "Fall Follow-up" (June, 2014) and "Fall Risk Assessment" (January, 2016) were complied with.

As per Ontario Regulation 79/10, s. 30, every licensee of a long-term care home shall ensure that there is a written description of each of the interdisciplinary programs required under section 48; and that the written description of the program includes relevant policies, procedures and protocols.

A Critical Incident Report (CIR) was submitted to the Director under the Long-term Care Homes Act (2007) on a specified date. The CIR was related to an incident that caused an injury to a resident. The resident involved in the CIR was resident #001.

According to a progress note, resident #001 was found to have experienced a fall on a specified date and time. After a period of time following the incident, resident #001 presented with signs and symptoms of an injury. Resident #001 was assessed, and the type of injury was confirmed at that time.

During an interview, RN #101 indicated to Inspector #655 that he/she had been the one who found resident #001 after the fall on a specified date. During the same interview, RN #101 indicated to Inspector #655 that after a resident has fallen, it is expected that a "Post Fall Screening Tool" be completed. RN #101 was unable to recall whether or not a Post Fall Screening Tool was completed for resident #001 after the resident had a fall.

Over the course of the inspection, RPN #102 and RN #104 indicated to Inspector #655 that when a resident has a fall, the post-fall assessment process involves the completion of a Risk Management Tool. Neither RPN #102 nor RN #104 spoke to the use of a Post Fall Screening Tool, as it was described by RN #101. According to RPN #102 and RN #104, there is also a Fall Risk Assessment tool (FRAT) that is used to assess residents related to risk for falls. Both RPN #102 and RN #104 indicated to Inspector #655 that residents are expected to be assessed using the FRAT on a quarterly basis; but are not expected to be assessed this way post-fall. Both RPN #102 and RN #104 indicated to Inspector #655 that after resident #001 had a fall, the Risk Management Tool was completed; but the FRAT was not done. RN #104 described the Fall Risk Management tool as an internal document that was used for statistical purposes.

During an interview, ADOC #105 indicated to Inspector #655 that the Post Fall Screening Tool described by RN #101 was trialed some time ago; but that it was no longer in use at the home. ADOC #105 was unable to speak to a current post-fall assessment process that involved the use of a clinically appropriate assessment instrument, specifically designed for falls.

During the inspection, Inspector #655 was provided with the following policies: "Fall Follow-up" (June, 2014); and "Fall Risk Assessment" (January, 2016). In each policy, it is indicated that a Fall Risk Assessment (FRAT) is to be completed after a fall has occurred in addition to the Risk Management Tool.

According to the policy titled Fall Follow-up (June, 2014), the Risk Management tool is to be completed, identifying possible contributing factors and identifying measures to put in place to prevent further falls, whenever a fall occurs. In addition, it is stated that a Fall

Risk Assessment (FRAT) is to be repeated at that time and documented in the Plan of Care.

During an interview, the RAI Coordinator indicated to Inspector #655 that the FRAT would have been expected to be conducted by a member of the registered nursing staff who worked on resident #001s' home area after resident #001 fell on the specified date.

During an interview, the DOC indicated to Inspector #655 that the FRAT is separate from the Risk Management Tool; and that the expectation is that the FRAT would also be conducted after a fall has occurred as stated in the policies.

The licensee failed to ensure that the policies "Fall Follow-up" (June, 2014) and "Fall Risk Assessment" (January, 2016) were complied with.

(Log #007629-17)

iii. The licensee failed to ensure that the policy titled "Bowel Regime" (0401-02-18), dated February, 2016, was complied with.

As per Ontario Regulation 79/10, s. 30, every licensee of a long-term care home shall ensure that there is a written description of each of the interdisciplinary programs required under section 48; and that the written description of the program includes relevant policies, procedures and protocols.

A Critical Incident Report (CIR) was submitted to the Director under the Long-term Care Homes Act (2007). The CIR was related to allegations of neglect, involving resident #002. According to the CIR, an allegation was made that staff had neglected resident #002 when the resident did not receive appropriate interventions related to bowel management.

During the inspection, Inspector #655 was provided with a copy of the policy titled "Bowel Regime" (0401-02-18), dated February, 2016. It was confirmed to be a current policy which registered nursing staff were expected to follow by ADOC #105.

According to the "Bowel Regime", dated February, 2016, registered nursing staff are expected to follow the following protocol when a resident experiences a specified condition related to bowel management:
- On the third day (that a resident experienced the condition related to bowel

management) – administer a specified pharmaceutical intervention,
- On the fourth day – administer a different specified pharmaceutical intervention,
- On the fifth day – administer another different specified intervention; and,
- On the sixth day – repeat the intervention provided on the fifth day.

During an interview, RPN #117 indicated to Inspector #655 that a Bowel Movement (BM) record is used to record residents' bowel movements. According to RPN #117, if a space on the BM record is left blank for a specified date, this would be indicative that the resident had not had a bowel movement on that day. If a resident had a bowel movement on the specified date, a descriptive notation would be documented on the BM record for the date on which the BM occurred.

During the same interview, RPN #117, indicated to Inspector #655 that if an intervention related to bowel management had been offered to a resident, including resident #002, it would be documented on the residents Medication Administration Record (MAR) (and not necessarily on the BM record); and, that the specific intervention that was administered would then be specified in writing on the reverse side of the same MAR. RPN #117 indicated to Inspector #655 that where a resident refuses an intervention, this information would be documented in the residents' progress notes.

During an interview, the DOC also indicated to Inspector #655 that the administration of an intervention indicated in one of the licensee's policies, such as the "Bowel Regime", would be documented on the residents' MAR. The DOC further indicated to Inspector #655, that if an intervention was offered, but had been refused, the refusal of the intervention would be documented in the residents' progress notes.

Inspector #655 reviewed resident #002's health care record including Bowel Movement (BM) Record, Medication Administration Record (MAR) including the reverse side, and progress notes.

According to the health care record, resident #002 was admitted to the home on a specified date with multiple diagnoses. According to the progress notes, resident #002 had experienced specified changes in his/her status over a specified number of days, including a condition related to bowel management.

During an interview, RPN #107 recalled an attempt to discuss bowel management with resident #002. According to RPN #107, when resident #002 had been approached on a specified date, resident #002 did not want to discuss bowel management with staff. RPN

#117 also recalled that a specified pharmaceutical intervention was offered to resident #002 for reasons related to bowel management at some point in time. According to RPN #117, resident #002 accepted the intervention at that time.

On review of resident #002s' health care record, Inspector #655 was unable to locate any documentation to indicate that resident #002 had received – or been offered - any interventions related to bowel management within the first three days that resident #002 had experienced a specified condition related to bowel management. Specifically, there was no documentation to indicate that resident #002 had been offered an intervention on the third day, as required by the licensee's "Bowel Regime" policy.

According to resident #002's health care record, resident #002 was offered a specified pharmaceutical intervention on the fourth day. On that day, resident #002 refused the intervention. According to the licensee's "Bowel Regime", the pharmaceutical intervention that was offered to the resident on the fourth day was actually to have been offered/administered on the third day. There was no documentation to indicate that resident #002 had been offered the intervention that would have been indicated on the fourth day, according to the licensee's "Bowel Regime", on the fourth day or on any other day over a period of a specified number of days.

According to resident #002's health care record, resident #002 was again offered the same pharmaceutical intervention on the fifth day. On that day, resident #002, again refused the intervention. According to the licensee's "Bowel Regime", a different intervention would have been indicated on the fifth day. There was no documentation to indicate that resident #002 had been offered the intervention indicated in the licensee's "Bowel Regime" for use on the fifth day.

According to resident #002's health care record, resident #002 was again offered the same pharmaceutical intervention on the sixth day. On the sixth day, resident #002 accepted the intervention. According to the licensee's "Bowel Regime", a different intervention would have been indicated for use on the sixth day. There was no documentation in resident #002s' health care record to indicate that resident #002 had been offered the intervention that was indicated in the licensee's "Bowel Regime" for use on the sixth day on that day.

According to resident #002's health care record, resident #002 was offered the intervention that is indicated in the licensee's "Bowel Regime" for use on the fifth and sixth days on the seventh day. On the seventh day, resident #002 declined the

intervention.

Inspector #655 spoke to resident #002 over the course of the inspection. During an interview, resident #002 recalled a period of a specified number of days in which the resident had experienced a condition related to bowel management. Resident #002 further indicated to Inspector #655 that he/she did not want to accept the specified pharmaceutical intervention that was offered to the resident on the fourth, fifth, and sixth days, because it is not an effective intervention for him/her.

During an interview on June 15, 2017, ADOC #105 also unable to locate any documentation to indicate that resident #002 would have received – or been offered – a specified pharmaceutical intervention, in accordance with the licensee's "Bowel Regime", on the third day that resident #002 had experienced a condition related to bowel management. ADOC #105 was also unable to locate any documentation to indicate that resident #002 had been offered the intervention that was indicated in the licensee's "Bowel Regime" for use on day four, at any time during a period of a specified number of days in which resident #002 had experienced a condition related to bowel management. ADOC #105 further confirmed that there was no documentation to indicate that resident #002 had been offered a specified intervention that was indicated for use in the licensee's "Bowel Regime" on day five and day six until after those days had passed.

The licensee failed to ensure that the policy titled "Bowel Regime" (0401-02-18), dated February, 2016, was complied with.

(Log #009900-17, Log #010078-17)

iv. The licensee has failed to ensure that the system used to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration was complied with.

As per Ontario Regulation 79/10, s. 68 (2), every licensee of a long-term care home shall ensure that the nutrition and hydration programs include a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

A Critical Incident Report (CIR) was submitted to the Director under the Long-term Care Homes Act (2007). The CIR was related to allegations of neglect, involving resident #002. According to the CIR, an allegation was made that staff had neglected resident

#002 when the resident did not receive appropriate interventions related to bowel management.

According to the health care record, resident #002, was admitted to the home with multiple diagnoses. In the health care record, two specific diagnoses were identified as being conditions which contributed to risks related to nutrition and hydration.

According to a progress note, entered by Food Services Supervisor #113, resident #002 was described as being a resident with identified risks related to nutrition and hydration.

In a Nutritional Screening and Assessment, resident #002 was again described as being a resident with identified risks related to nutrition and hydration. In the same assessment, a specific condition related to bowel management was identified as a potential issue for resident #002.

According to progress note, resident #002's oral intake was to be monitored closely.

Inspector #655 reviewed a written record of resident #002's bowel routine (for a period of thirteen days). According to the progress notes and the bowel record belonging to resident #002, resident #002 had experienced a condition related to bowel management over a period of a specified number of days.

Inspector #655 also reviewed resident #002s' current care plan. In an update made to resident #002s' care plan, it was stated that resident #002 was at risk for the same condition related to bowel management that resident #002 had experienced over a period of a specified number of days. It was further indicated in resident #002s' care plan that for that reason, hydration and nutrition interventions were in effect. According to RN #118, this referred to the monitoring of resident #002's food and fluid intake.

Inspector #655 reviewed the licensee's policy, #0401-03-42, dated January, 2016, related to bowel management. It was indicated in the policy that, unless contraindicated, staff are to follow general preventative measures for bowel management such as encouraging oral intake as required.

During an interview, Nutrition Manager #114 explained the system that is expected to be in place in order to monitor and evaluate the food and fluid intake of residents' with identified risks related to nutrition and hydration to Inspector #655. According to Nutrition Manager #114, it is the responsibility of nursing staff (i.e. PSWs) to monitor and

document each residents' food and fluid intake for each meal. Nutrition Manager #114 indicated to Inspector #655 that staff are expected to document a residents' intake on the Resident Care Flow Sheet. Nutrition Manager #114 further indicated to Inspector #655 that the Dietician uses the Resident Care Flow Sheets in conducting a dietary assessment.

Inspector #655 reviewed the Resident Care Flow Sheets belonging to resident #002.

On the Resident Care Flow Sheet for a specified one week period (week one), resident #002s' food and fluid intake was documented for only one meal. There was no documentation related to food or fluid intake for any other meal that took place during week one.

On the Resident Care Flow Sheet for another specified one week period (week two), neither food nor fluid intake was documented for any meal on three specified days. For all other days during week two, neither food nor fluid intake was documented for any breakfast or supper meals.

On the Resident Care Flow Sheet for a specified one week period (week three), the documentation of food and fluid intake was also inconsistent.

On review of resident #002s' Resident Care Flow Sheets, it was noted that the documentation related the monitoring of food and fluid intake was inconsistent, or missing entirely for several periods of time both before and after resident #002 had experienced a condition related to bowel management.

During an interview, RN #118 identified two other residents who were considered to be residents with identified risks related to nutrition and hydration (resident #008 and resident #009).

Inspector #655 reviewed the Resident Care Flow Sheets for both residents, #008 and #009, each for a period of three weeks. In the three week period (21 days), it would be expected that food and fluid intake would be documented for a total of 63 meals (three meals per day). For resident #008, documentation of food and fluid intake was found for only three out of the 63 meals; and for resident #009, documentation was found for only 18 of the 63 meals. The system used to monitor and evaluate the food and fluid intake of residents #008 and #009 was not complied with.

During an interview, PSW #120 indicated to Inspector #655 that staff are expected to monitor and to document food and fluid intake for all residents at each meal. At the time of the interview, Inspector #655 reviewed resident #002s' Resident Care Flow Sheet for a specific one week period with PSW #120. PSW #120 acknowledged the gaps in documentation of food and fluid intake, as described above. PSW #120 indicated to Inspector #655 that staff do monitor intake, but do not always document it.

Over the course of the inspection, the DOC confirmed that the Resident Care Flow Sheets are expected to be completed by staff every shift.

The licensee has failed to ensure that the system used to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration, including residents #002, #008, and #009 was complied with.

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 following policies are complied with: Safe Medication Administration, Fall Follow-up and Fall Risk Assessment, Bowel Regime; and to ensure that the system to monitor the food and fluid intake of residents with identified risks related to nutrition and hydration is also complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

The licensee has failed to ensure that resident #002 is dressed in accordance with his or her preferences.

During an interview, a family member of resident #002 indicated to Inspector #655 that resident #002 was dressed in clothing that did not belong to the resident and was not consistent with the residents' preferences on a specified occasion. The family member of resident #002 indicated to Inspector #655 that the resident may have been dressed this way for the reason of convenience.

Inspector #655 reviewed the health care record belonging to resident #002. According to resident #002s' current care plan, resident #002 prefers to pick out his or her own clothing.

During the inspection, Inspector #655 observed resident #002 to be wearing pants that were loose.

During an interview on the same day of the above-noted observation, resident #002 indicated to Inspector #655 that the pants did not belong to him/her. Resident #002 indicated to Inspector #655 that staff had chosen the pants because they were easier to put on. Resident #002 indicated to Inspector #655 that he/she would prefer to pick out his/her own clothing.

During another interview, resident #002 was observed to be wearing a different pair of pants which, according to the resident, were not consistent with the resident's preferences. At the time of the interview, resident #002 indicated to Inspector #655 that he/she had informed the staff that he/she did not want to wear that particular pair of pants that day; but was told by the staff that it was not possible to put the resident's preferred pants on that morning for two specific reasons.

On the same day as the above-noted interview, Inspector #655 observed resident #002 to be participating in a group activity, while wearing the same pants which were, according to the resident, not consistent with the resident's preferences. Resident #002 indicated to Inspector #655 that he/she had requested that the pants be changed before the activity; but was told by staff that they would change the pants after lunch. Resident #002 participated in the group activity while dressed in clothing that was not consistent with his or her preferences.

During an interview, PSW #106 indicated to Inspector #655 that resident #002 normally wears a specific type of clothing, including a specific type of pant and shirt. However, PSW #106 indicated to Inspector #655 that despite that, it had been observed that there

were many articles of clothing in resident #002s' room that were not consistent with the resident's preferences when PSW #106 first worked with the resident, approximately two weeks before. PSW #106 indicated to Inspector #655 that at that time, resident #002 asked if he/she could wear the specific type of pant he or she preferred. At that time, PSW #106 agreed to dress resident #002 in accordance with the residents' preferences– PSW #106 assisted the resident to get dressed; and, according to PSW #106, resident #002 was also able to participate, in order to facilitate the dressing of resident #002 in the residents' preferred type of clothing.

During an interview, PSW #120 indicated to Inspector #655 that he/she had provided morning care, including assistance with bathing and dressing, to resident #002 with the help of a second staff member, PSW #108, that day – the same day that resident #002 was dressed in pants that were not consistent with the resident's preferences. During the interview, PSW #120 indicated to Inspector #655 that resident #002 was capable of choosing his or her own clothing – but, that his/her choices were not appropriate. PSW #120 explained to Inspector #655 that resident #002 does not want to wear a specified type of clothing; but, for a specific reason, resident #002 cannot be dressed in the resident's preferred type of clothing during morning care. PSW #120 confirmed that on that morning, PSW #120 and PSW #108 had dressed resident #002 in a pair of pants from the home's boutique. The pants did not belong to resident #002, and they were not consistent with the resident's preferences.

During an interview, ADOC #105 indicated to Inspector #655 that discussions related to resident #002s' clothing had taken place with the resident and the family member of resident #002. However, ADOC #105 indicated to Inspector #655 that the resident wanted to continue to use his/her own clothing. ADOC #105 indicated to Inspector #655 that at this time, it is expected that resident #002 be dressed in his or her own clothing, in accordance with the residents' preferences.

The licensee failed to ensure that resident #002 was dressed appropriately, in keeping with the resident's preferences.

(Log #009900-17)

WN #3: 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 :

The licensee has failed to ensure that access to all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

During the inspection, Inspector #655 observed a staff member, Environmental Services Aide #116, to enter a medication room on a specific resident home area; and then proceed to enter the medication room on another resident home area. In both cases, Environmental Services Aide #116 was observed to enter the medication rooms alone. Both medication room doors had been locked at the time of the observation.

At the same time, RN #118 confirmed to Inspector #655 that the Environmental Services Aide had in fact entered both medication rooms.

During an interview, Environmental Services Aide #116 explained his/her role to Inspector #655, which included various duties within the environmental services department, including shipping and receiving.

During an interview, the DOC indicated to Inspector #655 that Environmental Services Aide #116 generally performs cleaning duties and has no clinical background. The DOC further indicated to Inspector #655 that the Environmental Department has a master key, with which environmental staff are able to access medication rooms.

Before the end of the inspection, the DOC indicated to Inspector #655 that the master key was no longer in the possession of the Environmental Services Department; but confirmed that prior to that time, the environmental staff did have access to medication rooms.

The licensee has failed to ensure that access to all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

Issued on this 23rd day of June, 2017

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

Original report signed by the inspector.